

APPROACHING 2000:
MEETING THE CHALLENGES TO
SAN FRANCISCO'S FAMILIES

THE FINAL REPORT OF THE MAYOR'S TASK FORCE ON FAMILY POLICY



ART AGNOS, MAYOR
JUNE 13, 1990

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LETTER OF TRANSMITTAL

To the Honorable Art Agnos, Mayor, and to the People of San Francisco:

It is with great pride and with a sense of accomplishment that I transmit to you the final report of the Mayor's Task Force on Family Policy.

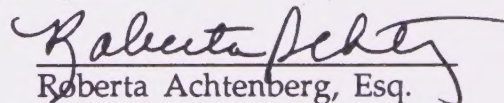
In June 1989, this Task Force was charged to examine two issues critical to the well-being of families in San Francisco: 1) whether the employment benefits provided to City workers could be expanded to include health insurance coverage for the domestic partners and extended family members of those workers; and 2) whether the operation of City government should be altered in an effort to be more supportive of the diverse family structures found in San Francisco today.

Recognizing that it is in the interest of the City and County of San Francisco to encourage rich, constructive family life, irrespective of family form, we were asked to determine if existing laws and policies were undermining family formation and protection, and if so, to make recommendations about how the City could act more constructively in that regard. This report contains our findings and recommendations for change.

The Task Force has done exhaustive research, including a statistical survey of City workers. We have investigated the operations of City departments and/or agencies which provide services to the people of San Francisco. We have listened to the people of San Francisco in private meetings and in a public hearing. Both individual San Franciscans and representatives of the various organizations which serve the City's families have given us their views on how the City and County's policies affect families and what changes might make San Francisco **family-friendly** to all its families.

The report we deliver to you today summarizes the conclusions we have drawn and makes recommendations based on our year long effort. The Task Force believes that changes made in city policy in conformity with this report will help to make family life richer and more rewarding for San Francisco's diverse families.

It has been an honor and a privilege for me to chair the Task Force on Family Policy. Our distinguished members have been hard working, probing, thoughtful and cooperative as we have striven to tackle the difficult and unique issues which our charges presented. We thank you, Mr. Mayor, the Board of Supervisors, and the people of San Francisco, for the cooperation, the sensitivity and the vision which helped make this report possible.

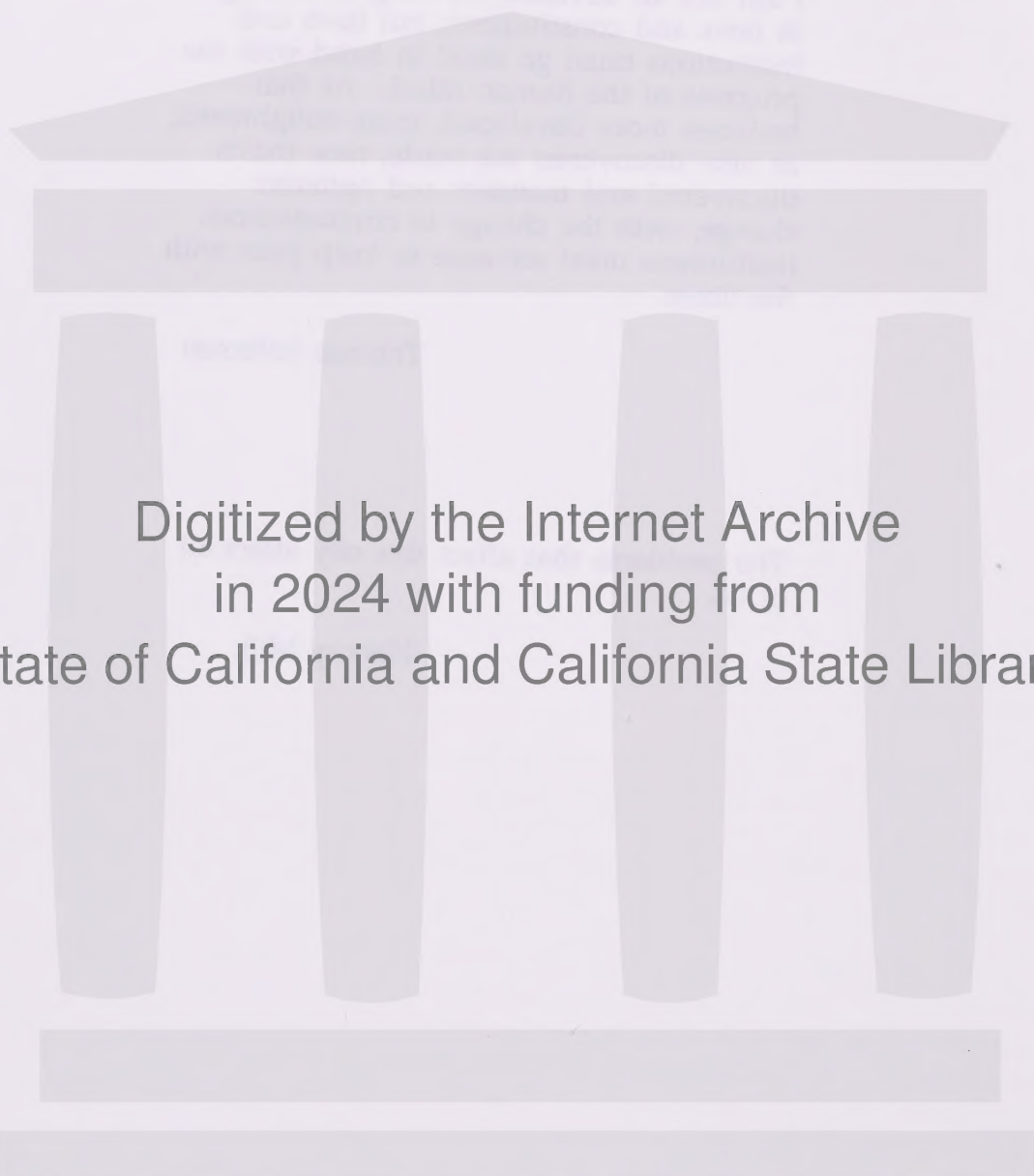

Roberta Achtenberg, Esq.

I am not an advocate for frequent changes in laws and constitutions, but laws and institutions must go hand in hand with the progress of the human mind. As that becomes more developed, more enlightened, as new discoveries are made, new truths discovered and manners and opinions change, with the change in circumstances, institutions must advance to keep pace with the times.

Thomas Jefferson

The problems that affect this city affect all of us.

Harvey Milk



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TABLE OF CONTENTS

EXECUTIVE SUMMARY	1
THE MAYOR'S TASK FORCE ON FAMILY POLICY	7
INTRODUCTION	11
GUIDING PRINCIPLES AND METHODOLOGY	12
RECOGNIZING THE REALITY OF THE AMERICAN FAMILY	14
THE CITY OF SAN FRANCISCO AS AN EMPLOYER	18
Approaching 2000: The Challenge of Change	18
San Francisco's Response	19
Changes in Leave Given to City Employees	20
Family care leave	20
Sick/bereavement leave	22
Religious leave	23
Changes in the Provision of Health Care Benefits	24
A system in need of revision	24
Health care benefits for extended families	26
Health care benefits for domestic partners	29
The Retirement System	37
MUNI Passes	38
Other Family-Friendly Policies	39
Modification of standard work rules	39
Child care	39
Elder care	40
Implementation	41
THE CITY OF SAN FRANCISCO AS A PROVIDER OF SERVICES	43
Payments to Relatives as Foster Parents	43
Emergency Foster Care in Case of a Crisis	43
Foster Care Placement Issues	44
Fraud Early Detection and Prevention Program (FRED)	46
Visitation in Intensive Care Units	
or Other Restricted Units in City Health Facilities.	47
Family Related Services of the Department of Public Health	48
In-Home Supportive Services	48
Coroner's Office	49
Family Violence	50
THE CITY OF SAN FRANCISCO AS A CONTRACTOR OF SERVICES	51

Discrimination Against Families in Homeless Shelters	51
Nutrition Programs for the Elderly	51
OTHER FAMILY ISSUES AND RECOMMENDATIONS	53
Housing Issues	53
Property Tax Reassessment	55
Family Registry	55
Monitoring and Implementation of Recommendations	57
Lobbying Efforts	57
ENDNOTES	58
APPENDICES	64

EXECUTIVE SUMMARY

o INTRODUCTION

This report is, as Mayor Agnos requested, a report about the problems which **ALL** San Francisco families face because of the laws and policies of the City and County of San Francisco or the implementation of these laws and policies by City departments and/or agencies. The Task Force is making recommendations which, if followed, will make the government of the City and County of San Francisco more responsive to the needs of its families.

Many of the recommendations in this Task Force Report apply to all of San Francisco's families. Although there are issues which are unique to some families, all families face many of the same challenges. Additionally, a goal of this report is to be as inclusive as possible, and some of the Task Force's recommendations have a more significant impact on some kinds of families than others. Thus, while the report covers issues of concern to the heterosexual nuclear family, it also addresses some of the unique problems faced by extended families and alternative families. The report further attempts to focus on some of the unique problems faced by families in San Francisco's many racial and ethnic communities. Unlike most reports dealing with the family, this report deals with problems faced by lesbian and gay male families.

In total, the combined effect of the Task Force's recommendations is to support each individual in the family which he/she forms and to remove the adverse impact which City policies and practices may have on a person's family choices.

o MEANING OF THE TERMS FAMILY AND DOMESTIC PARTNERS

San Francisco possesses one of the most ethnically and culturally diverse populations of any city in the United States. Thus, the Task Force adopted a description of family which it believes reflects this diversity and which is as inclusive as possible. When we speak of **family** in this report we mean:

a unit of interdependent and interacting persons, related together over time by strong social and emotional bonds and/or by ties of marriage, birth, and adoption, whose central purpose is to create, maintain, and promote the social, mental, physical and emotional development and well being of each of its members.

One kind of family to which this report refers frequently is one in which domestic partners are members. By **domestic partners** the Task Force means two people who have chosen to share all aspects of each other's lives in an intimate and committed relationship of mutual caring and love. The report utilizes this term for two reasons. First, the Task Force believes that the relationships of committed couples are entitled to respect, regardless of marital status. Second, since lesbians and gay men are not at present permitted to marry, recognition of domestic partnership is the only way to treat their relationships with the equal dignity to which they are entitled.

o **COST TO THE CITY**

A basic operating principle of the Task Force was to consider the economic consequences of each recommendation and to make only recommendations which would be cost effective and within the City's financial means.

o **THE CITY AS AN EMPLOYER**

The Task Force is making many recommendations about the employment practices and policies of the City. In so doing, the Task Force has operated under the principle of equalizing the benefits received by City employees based on family status. However, in no case has the Task Force made a recommendation which equalizes benefits by terminating benefits currently provided to City employees.

The American workforce is changing - growing more slowly, becoming older, comprising more women, minorities and immigrants. Employers, including the City of San Francisco, must meet the challenges of this changing workforce as well as reconcile the conflicting needs of work and families.

The Task Force believes that the City's workplace policies and benefits should be as friendly to all types of families as possible. The policies recommended in this report respect the diversity of workers and their families. They are also sound employment practices because they create a more supportive work environment for all workers, and reduce on-the-job stress, as well as job turnover, tardiness, and absenteeism.

Recommendations:

o **Unpaid family care leave of up to a total of one year within a two year period should be provided to City employees.** This leave would allow an employee to address serious and time-consuming family issues, such as the serious health condition of a spouse, domestic partner, child, parent or other family member who is dependent upon the employee. This leave would also include parenting leave. This leave can be created by a rule change by the Civil Service Commission.

- o **The bereavement leave policy for City employees should be modified.** Bereavement leave should be explicit in its application to the death of a domestic partner and also applicable to the death of any other person to whom the employee may be reasonably deemed to owe respect. This modification will require a rule change by the Civil Service Commission and ratification by the Board of Supervisors.
- o **Religious leave for City employees should be provided.** Employees should be able to choose to work compensatory overtime for the purpose of taking time off without charge to leave when personal religious beliefs require that the employee abstain from work during certain periods of the workday or workweek.
- o **The City employee health insurance system should be revised.** San Francisco contributes nothing for the coverage of spouses and children; the employee pays the total premium for them. This policy is different from the policies of most other municipalities and private employers, and puts the City, its workers and its insurers at a disadvantage. Any revision of the system requires a Charter amendment.
- o **Health care insurance benefits should be provided to approximately 4650 children of City workers who are currently excluded from coverage.**
- o **Health care insurance benefits should be provided to approximately 2100 domestic partners of City workers.** The City's health insurance providers agree that such coverage can be provided at reasonable cost. This would require revision of the City employee health insurance system by the Health Service Board and Board of Supervisors.
- o **A new task force should be appointed to study revisions to the City employee retirement system.** Such revisions would include making domestic partners eligible for the automatic continuation of full pension payments upon the death of a City employee and removing the current termination of benefits to the surviving spouse upon remarriage.
- o **The City should be more aggressive in modifying standard work rules and policies and making them family-friendly.** The City should consider flextime, job sharing, flexplace, and reduced hours for City employees.
- o **The City should expand affordable, quality on-site day care in City agencies and/or departments, and should also provide sick child care for children who are mildly ill.**

- o In order to confront the growing problem of elder care, the City should use already existing resources to refer employees to City programs and community-based organizations.

- o Effective implementation of the Task Force's recommendations requires training of managers and notification to employees.

- o An Office of Employee Benefits for City employees should be created. This office would serve as a centralized place to advise City employees of the options which are open to them concerning benefits. The Office of Employee Benefits would also expand employee assistance programs and provide career, financial and retirement planning information.

- o **THE CITY AS A PROVIDER OF SERVICES**

The City's policies and practices in delivering services to the people of San Francisco should be family-friendly. By not serving the needs of all the people and families of San Francisco, the government disadvantages some of the people it was intended to serve.

Recommendations:

- o **Payments should be made to relatives as foster parents.** The state-run foster care program will not make payments to relatives who are providing foster care. This has a particularly negative impact on the African-American community. A majority of all children in foster care in San Francisco are African-American, and it is not unusual in the African-American community for grandparents or other relatives to be foster parents of children related to them. The Task Force supports Assembly Bill 1060, which will change the law and permit payments to relatives.

- o **A domestic partner should be recognized as a relative of a child for whom he/she has assumed parenting responsibilities.** If the domestic partner had this status, then in case of a serious accident or incapacitating illness to the child's other parent, the child could remain at home with the domestic partner. Currently, the Department of Social Services will license the domestic partner as a foster parent, but this policy is open to legal challenge by other relatives.

- o **The Department of Social Services (DSS) should create policies and undertake programs to strengthen families so that placement into foster homes is not necessary.** DSS should also more actively recruit African-Americans to become foster parents. Under a successful recruitment program, out-of-county placement of African-American children could be minimized or eliminated.

- o A pilot program under Greater Avenues for Independence (GAIN) should be established to direct GAIN enrollees to medically related training so that they can qualify to become foster parents of medically fragile infants. These infants would then receive the care they need and be able to remain in their communities.

- o The Department of Social Services (DSS) should reconsider the Fraud Early Detection and Prevention Program (FRED) because it is destructive of family life. It may be that by working with the affected communities, DSS can establish a substitute eligibility verification program. However, DSS should also communicate effectively with the affected communities about FRED's purpose and operation, minimize use of collateral interviews, and end delays in issuing aid because of FRED investigations. The Task Force supports DSS's recent elimination of home visits.

- o The Health Commission should issue a written policy, utilizing the Task Force's description of family, which regulates visitation of patients in intensive care units in City facilities. The description of family should also apply to family related services supplied by the Department of Public Health.

- o The City should lobby in Sacramento to prevent elimination in the Governor's 1990-91 budget of payments to relatives who provide In-Home Supportive Service to family members.

- o THE CITY AS A CONTRACTOR OF SERVICES

There is an increasing trend in government for a variety of government services to be contracted to private companies. When the City has private companies provide services to its citizens and families in its place, these services should be provided in conformance with the City's family policy, and should utilize the Task Force's description of family.

Recommendations:

- o The Department of Social Services (DSS) should adopt the Task Force's meaning of family for insertion in its contracts which provide shelter to homeless families. This would ensure that gay male or lesbian couples with children would not be excluded from family shelters.

- o Federal regulations pertaining to City administered nutrition programs for the elderly should be revised so that domestic partners under age 60 can receive meals at the same rate as a spouse.

o **OTHER ISSUES AND RECOMMENDATIONS**

o **Expiring Section 8 housing contracts must be replaced with programs to ensure that low income families are not displaced.** The City should work with the U. S. Department of Housing and Urban Development, as well as lobby Congress, to address this issue. The Task Force also supports the San Francisco Housing Preservation Ordinance which has been introduced by Supervisor Ward.

o **A family registry system should be created.** This registry would establish a system for making an official record of extended and alternative families (distinguishing those in which children are members) and a separate system for making a record of committed couples.

o **A Commission on Children, Youth and Families should be created.** This commission would oversee and coordinate policies affecting families. In the interim, a subgroup of the Task Force on Family Policy should remain in place to monitor implementation of the Task Force's recommendations.

o **The City should lobby in Sacramento and Washington for legislation which is friendly to the families of San Francisco and as inclusive as possible.**

THE MAYOR'S TASK FORCE ON FAMILY POLICY

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INTRODUCTION

The family is the basic unit of societal organization; it provides for its members' emotional, financial and social support. Today, there is much discussion regarding preserving and protecting the family, as well as upholding certain family values. These discussions are sometimes emotional, rather than analytical. For many people, understanding of the term family tends to be based less on the way families are in fact constituted, and more on their perceptions of what a family is supposed to be. If our perception is that a family consists of a mother who does not work outside the home, a father who is the breadwinner, and two children, we then tend to view families with one parent, two parents of the same sex, families without children, or families with extended family and nonblood related members, as families with deficiencies or not as families at all.

Yet today, demographics prove that family structure is more diverse than ever. It is important to recognize that these diverse families are fully functional and supportive of their members, helping to enrich and contribute to society. Moreover, denying the existence and legitimacy of families as they really exist today is not sound public policy.

The challenge facing the Mayor's Task Force on Family Policy was not to redefine family, but to make sound public policy recommendations based on the many kinds of families we do have in our city. We have attempted to combine realism, compassion and practicality in making our recommendations. The areas we are reporting on are complex, and many deserve their own task force reports. Yet we were able to reach consensus in many key areas. We think these recommendations will aid in the preservation of our families, no matter what form they take.

GUIDING PRINCIPLES AND METHODOLOGY

The government of the City and County of San Francisco strongly influences the family life of its residents. Whether this influence is beneficial or detrimental, inclusive or exclusive, initially depends to a great extent on how the term family is legally defined in the City's Charter and ordinances. The Task Force thus began its work by examining both the Charter and Administrative Code as they impact on families.

The Task Force next reviewed the policies of key City departments, agencies and commissions.¹ The Task Force looked at the departments and/or agencies in three capacities: as employers, as providers of services, and as contractors. The purpose of each review was to determine if the department and/or agency's policies and regulations, or its implementation of its policies and regulations, were disadvantaging families. The Task Force analyzed the information received from these reviews and, meeting more than thirty times in two subgroups, formulated proposed recommendations.

The Task Force also conducted an inclusion process. During this process, members of San Francisco's many racial and ethnic communities, the lesbian and gay male community, the business community, and representatives of community-based organizations, were interviewed and conferred with.² These interviews gave the Task Force a chance to discuss its preliminary findings with a broad representative sampling of the public, and to ensure that its research had not missed any issues of vital concern to a particular community.

The Task Force held a public hearing on March 29, 1990. The hearing was co-sponsored by the Human Rights Commission, on behalf of which four Commissioners attended the hearing. The Mayor also attended and spoke at the hearing. Representatives of City agencies, employees, and health insurers testified. Members of the public, as well as representatives of community-based organizations and religious institutions and organizations, were also provided an opportunity to testify. A total of forty-three persons testified at the hearing.³ Written submissions were also accepted.

After considering all of the information it had received, the Task Force adopted its final recommendations, which are presented herein. Some of the Task Force's recommendations can be implemented by City departments and agencies through changes in policies and/or regulations. Other proposed changes will require action by the Board of Supervisors to amend existing ordinances or pass new ordinances. Some proposals will require amendments or additions to the Charter, while other proposals can only be implemented by changes to state or Federal laws, policies or regulations. In these latter cases, the Task Force recommends that the City use its lobbying power to bring about the recommended changes.

It should also be noted that in making recommendations concerning the employment practices and policies of the City, the Task Force operated under the principle of equalizing the benefits received by City employees based on family status. However, a basic operating principle of the Task Force was that in no case would the recommendation to equalize a benefit result in the removal of any benefits currently provided to City employees. Another basic operating principle of the Task Force was to consider the economic consequences of each recommendation and to make only recommendations which the Task Force believes are cost effective and within the City's financial means.

RECOGNIZING THE REALITY OF THE AMERICAN FAMILY

Differences of race, religion, culture, ethnicity, and sexual orientation among people all create diverse types of effective and functioning families. This is not a recent phenomenon. Family diversity has always been present, though not necessarily recognized and/or spoken about, in American society. In recent decades, alternative and/or extended families have been kept out of mainstream America, often forced into an isolation they were told they deserved. These families, as well as the individuals which constitute them, are seeking the recognition, respect, and benefits which have previously been accorded only to the family which fit the popularized conception of the typical American family. Under this conception, a typical family included a father who was the sole breadwinner and a mother who stayed home to provide support for the working husband, to care for the children, and to do the housework. Any group of people that did not fit this definition was not considered a family.

Many Americans do live in heterosexual nuclear families, but this kind of family is changing. Real wages have declined and rather than the father as the sole breadwinner, both parents in the heterosexual nuclear family now usually work outside the home. In 1984, 61 percent of all married women with children were in the labor force - more than twice the 1960 rate of 28 percent.⁴ The total workforce is now 45 percent women, and it is projected that even more women will enter the labor force. Women will constitute two-thirds of all new entries in the labor force between 1986 and 2000.⁵ This economic factor has already greatly affected the heterosexual nuclear family, and will continue to do so.

An American family may also be headed by a single parent, who is usually a woman. In 1980, there were 2.4 million marriages in the United States and 1.2 million divorces. The percentage of children under 18 living in single parent households has increased significantly, from 9% in 1960, to 12% in 1970, and to 23% in 1985.⁶ A recent report by the House Select Committee on Children, Youth and Families shows that when compared to 11 other industrialized nations, the United States has the highest number of children under 18 whose parents have divorced, as well as the highest number of families headed by a single parent.⁷

The City and County of San Francisco further reflects this diversity of effective and functioning families, giving new meaning to the phrase E PLURIBUS UNUM - one formed from many. San Francisco's population has a higher proportion of racial and ethnic minorities, particularly Asians and Pacific Islanders, than the population of the United States as a whole.⁸ It also has a higher proportion of recent immigrants,⁹ and it has a large number of lesbians and gay men.¹⁰ The population of San Francisco also contains a higher percentage of persons over age 65 than does the country as a whole.¹¹

Religious diversity is a hallmark of San Francisco, with many persons observing Eastern, rather than Western, religions. For example, in one block of Chinatown one can see places of worship for Buddhists, Taoists, Presbyterians, and ancestral worshippers.

San Francisco's Asian/Pacific Islander population contains a diversity which is hardly matched anywhere else. Included in the Asian population are Chinese from the People's Republic and Taiwan, Southeast Asians, Cambodians, Thais, Asian Indians, Filipinos, Koreans, Japanese, Vietnamese, and Indochinese hill people.¹² Pacific Islanders come from such islands as the Hawaiian Islands, Guam, Samoa, and Fiji.

Many Asian/Pacific Islander families, including families which have been in the United States for generations as well as newcomers, are multi-generational in structure. In some cases, Asian/Pacific Islander family structure is different from that familiar to many Americans. For example, in the Samoan culture, people are considered to be aunts or uncles because they came from the same village. Due to the laws and family policies in this country, these important relationships are frequently not recognized.

The African-American community in the United States faces multitudinous stresses and continuing challenges caused by prejudice and discrimination which affect all aspects of life - jobs, housing, health, education, self respect and self esteem. In addition to this prejudice and discrimination against African-Americans as a group, the structure of many African-American families has been disregarded or deprecated because it is different from that of many Caucasian Americans.

In San Francisco's African-American community, it is not unusual for women such as grandmothers and aunts to play a prominent role in the family. The 1980 census showed that 46.8 percent of African-American family households in San Francisco were headed by women.¹³ Extended family members who are not related by blood or marriage may also provide love and support to an African-American family.

Latinos are the fastest growing ethnic group in the United States and come from many different countries, each with a distinct national culture. Of the Latinos in San Francisco, 39 percent are of Mexican origin; 6.2 percent are Puerto Rican; 1.9 percent are Cuban; and 52.9 percent are of other Latino origins.¹⁴ As with the African-American and Asian/Pacific Islander communities, Latino family orientation often extends beyond immediate relatives. This extended family includes the kinship of close family friends who are given the status of relatives (literally coparents). These persons are treated like family members in most respects.¹⁵

Gay male and lesbian families also play a prominent role in San Francisco. A report by the San Francisco Examiner in June 1989 showed the stability of gay male and lesbian family life in the San Francisco. Most lesbians and gay men in San Francisco have domestic partners; 58% of gay men and 81% of lesbians are currently involved in a relationship.

Gay men and lesbians increasingly are parents, dealing with the same family issues as other families. An estimated one third of lesbians are mothers.¹⁶ In San Francisco alone, at least 1,000 children have been born into lesbian and gay male families in the last five years.¹⁷ Lesbians and gay men have increasingly sought to become licensed foster parents and adoptive parents.

Lesbians and gay men are subject to prejudice and discrimination in all walks of life, ranging from employment to education; judicial remedies for this bigotry are limited. The prejudice and discrimination suffered by this community, sometimes erupting into violence, has persisted throughout most of history.¹⁸ The effects are particularly felt by lesbian and gay male families. At best, lesbian and gay male families are invisible; at worst, they are considered unfit. Various measures, both informal and legal, have been taken by many lesbians and gay men to preserve and protect their families, but these families still remain relatively unprotected and unrecognized by the law.

The Task Force concludes that the diversity of San Francisco, coupled with economic and societal changes, demands that the term **family** be given a flexible meaning. It is clear that in America today a family is not just a heterosexual married couple and their children. There are other families, such as multigenerational and extended families, single parent families, gay male and lesbian families with or without children, families where children are raised by grandparents or other relatives, and immigrant families which reflect both the immigrant experience and different cultures. Moreover, there are families which combine many of these different attributes.

The Task Force concurs with the conclusion of the Task Force on Family Diversity in Los Angeles that important public policy goals are served by the utilization of a meaning of the term **family** which reflects the diversity of contemporary family structures:

Families of all definitions have traditionally cared for society's dependent members, like children, the elderly, the disabled, the sick and the poor. Families discipline their members, and to the extent they are successful, contribute to the general peacefulness of society. Families live in groups, or neighborhoods, providing stability for surrounding commercial and cultural activities. And on the most personal level, families provide a haven and a source of renewal for those who are their

members. Families are a great source of meaning and satisfaction to individuals, and the loss of a family arrangement or relationship can leave individuals disoriented and alienated. If government benefits are unavailable or closely restricted, families can become destabilized and will eventually pose further problems for which governments will have to expend funds. There is a general intuition among scholars, service providers, and ordinary citizens that family destabilization is a major cause of the majority of our society's ills.¹⁹

The Task Force has adopted the following meaning of the term family, which it believes represents a functional approach to describing a family in San Francisco - indeed, in America - today. This description of family has been drawn from one developed by the Department of Family Health Care Nursing at the University of California at San Francisco nearly twenty years ago and which is still in use. This description, which appreciates the fundamental significance of enduring nonmarital and nonblood relationships, is viewed as sound by those who study the family and by practitioners who serve families.²⁰ Thus, a family is:

a unit of interdependent and interacting persons, related together over time by strong social and emotional bonds and/or by ties of marriage, birth and adoption, whose central purpose is to create, maintain, and promote the social, mental, physical and emotional development and well being of each of its members.

It should be noted that in making some of its recommendations, the Task Force found it necessary to adopt or discuss subgroupings of the term family. However, unless so noted, the term family will encompass the more expansive and flexible description.

THE CITY OF SAN FRANCISCO AS AN EMPLOYER

I. Approaching 2000: The Challenge of Change

In performing its analysis of the City as an employer, the Task Force recognized the necessity of reassessing the needs of people, their families and the workforce. Societal changes require new workplace policies. The American workforce is growing more slowly,²¹ becoming older,²² and comprising more women,²³ minorities²⁴ and immigrants.²⁵ Yet most current policies and institutions covering pay, fringe benefits, time away from work, pensions, and other issues were not designed for our society's cultural diversity.

Under the old workforce ethic, it was assumed that the employee would always stay on a rigid work schedule and would be absent only for scheduled vacations or when ill or disabled. Family emergencies or special events were not recognized as interfering with an employee's work performance and were to be managed outside of normal working hours or through the use of personal vacation time. Although almost all adult family members now work outside the home, rigid work schedules and the old assumptions regarding family life continue to be used by most public and private employers. Thus, employees are forced to act either as if they never have family responsibilities during work hours or, if these responsibilities are acknowledged, then the employee must act as if someone is home during the day to take care of them.²⁶

In reality, conflicts do arise between work and family life, because workers have personal and family problems and responsibilities that affect them during their work hours. The Congressional Office of Technology Assessment has reported that the personal problems of employees cost U.S. industry \$137.6 billion a year. In response, a recent trend in companies is the development or expansion of employee assistance programs (EAPs) to address employees' personal problems through counseling and referrals to appropriate assistance agencies.²⁷

A Corporate Work and Family Life Study (CWFLS) conducted by Bank Street College²⁸ showed that balancing job and family demands is extremely difficult for the majority of parents. The period of time before children enter elementary school (under 6 years) seems to be the hardest of all for both employed fathers and mothers. There are typical times and situations when parents miss work, or are under stress because of work-family concerns. Working parents miss work to care for a sick child, to care for a child when the regular provider of child care is unavailable for the day, or to search for a new child care provider. In addition to worry over the quality or reliability of child care for younger children, stress at work often arises from worry about an older child who is caring for himself or herself. Parents often need time away from work for children's medical appointments, teacher conferences, and visits to schools or child care centers to observe children's performances, as well as that of the care providers.

There has been less research on how work conditions affect employees' care of aging parents or other relatives. It is known, however, that women, by and large, provide this care. It is further projected that because of the entrance of more women into the labor force, the declining birth rate, and the increase in the number of aging people, fewer family members will be available to provide care for the aging.²⁹ This decrease in available care providers will cause greater stress on those that do provide such care to elderly relatives.

Thus, it is becoming increasingly clear that work and family life are not separate but are linked in profound ways. The question is how employers will respond.

II. San Francisco's Response

It will be necessary for all employers, including the City and County of San Francisco, to reconcile the conflicting needs of work and families. It is clear to the Task Force that supportive work environments which ease the tension between work and family responsibilities make it easier for people, especially minorities and those with low incomes, to work.³⁰ The Task Force recommends that the City's workplace policies and benefits should be as family-friendly as possible and should utilize the life cycle approach to personnel policies and benefits. Under the life cycle³¹ approach, an employer supports employees and their families at important turning points in life, such as marriage or commitment by two persons, birth, the assumption of child care responsibilities, separation and/or divorce, and death.

Such policies are being adopted nationally by many employers. However, other employers have failed to recognize and support the diversity of the families of their employees, particularly gay male and lesbian employees and single parent households. Respecting the diversity of workers and their families creates a more supportive work environment for all workers.³² The life cycle approach to personnel policies and benefits can be successfully tailored to reflect the diversity of the workforce because the life events which are focused on can be selected to reflect the lifestyles and needs of the particular workforce.

Family-friendly policies can reduce on-the-job stress, as well as the job turnover, tardiness, and absenteeism that oftentimes result from disruptions in family life. Family-friendly policies are cost effective, in that they allow workers to be more productive, as well as more physically and psychologically healthy. These policies and benefits also promote the health and well-being of the families of City employees, which strengthens the City. Thus, the Task Force believes that the government of the City and County of San Francisco should become a model employer in the Bay area and in the nation.

A. Changes in Leave Given to City Employees

Civil Service Rule 22 sets forth the types of leave to which City employees are entitled: vacation leave; sick leave; personal leave; military, war effort and sea duty leave; leave to accept an exempt or temporary appointment in the City or County service; educational leave; leave for civilian service in the national interest; leave for employment as an employee organization officer or representative; witness or jury duty leave; and holiday leave. The Task Force reviewed these leave policies and recommends the following changes to make them more family friendly.

1. Family care leave

Personal leave is a "catch-all" unpaid leave which is granted to City workers entirely at the discretion of an employee's supervisors. This leave is designed for reasons other than those covered by the other leaves, such as for travel, employment outside of the City, continued education, or care for a family member. It is granted for up to one year within any two year period. However, the employee may request an extension. The Task Force believes that leave to take care of a family member should be a different type of personal leave, as family problems can adversely affect the performance of an employee.

Employers are increasingly granting a certain amount of unpaid leave to an employee to deal with serious family issues which will take a significant amount of time to address. Such issues include the serious health condition of a spouse, domestic partner, child, parent, or other family members who are dependent upon the employee and parenting a new child in the family. The Task Force recommends the creation by the Civil Service Commission of an unpaid **family care leave** of up to one year within any two year period for City workers.

The creation of family care leave recognizes the importance of taking care of family members and the salutary effects this type of leave can have on an employee. Indeed, an overwhelming majority of Americans (81%) think that employers should be required to provide an unpaid leave of absence for the birth or adoption of a child or the illness of a family member.³³ Family care leave is also the subject of legislative activity on both the state and Federal levels. Since 1972, 25 states and Puerto Rico have passed laws that in some form protect employees who must leave their jobs temporarily for family reasons.³⁴ Most recently, on May 4, 1990, New Jersey's Family Leave Act, P.L. 1989, c. 261, went into effect. Bills are pending in Congress (H.R. 770, passed by the House of Representatives on May 10, 1990, and S. 345) and in the California State Assembly (A.B. 77) to provide, inter alia, for family care leave.

Family care leave for City employees should also encompass the already existing leave granted for care of a new child in the family, i.e., parenting leave. Employees currently may be granted up to one year of child care leave when becoming a parent of a newly-born child or of a legally adopted child up to five years of age. The problem with the current policy is that a narrowly defined legal relationship is needed between the child and the employee wishing to take the leave. In some families it is possible that no such legal relationship exists (domestic partner families or families in which a godparent will care for the child). In other families, if a legal relationship does exist (families in which grandparents or aunts and uncles care for the children), the relationship does not fit into the narrow legal definition which is a prerequisite for taking leave. In each of these families, the employee does not currently qualify to take leave, even though he or she is in fact responsible for parenting the child.

In order to rectify this problem, the Task Force recommends that family care leave for a new child in the family be granted to any City employee who has assumed parenting responsibilities. Such responsibilities would include providing emotional and psychological support to a child and agreeing to provide, or in fact providing, financial support. Family care leave for parenting would not apply to an employee who temporarily cares for a nonrelated child for nonetary compensation, such as a paid child care worker.

In summary, the Task Force recommends that employees be permitted to take unpaid family care leave for the following reasons:

1. the birth of a biological child of the employee;
2. the placement of a child with the employee in connection with adoption;
3. the assumption by the employee of parenting or child rearing responsibilities; or
4. the serious illness or health condition of a family member of the employee (including but not limited to, the employee's spouse or domestic partner, a parent of the employee or the employee's spouse or domestic partner, the biological or adoptive child of the employee, or a child for whom the employee assumes parenting or child rearing responsibilities); or

5. the mental or physical impairment of a family member of the employee (including but not limited to, the employee's spouse or domestic partner, a parent of the employee or the employee's spouse or domestic partner, a biological or adoptive child of the employee, or a child for whom the employee assumes parenting or child rearing responsibilities), which impairment renders that person incapable of self-care.

The employee's supervisor would not have sole discretion to grant or deny family care leave. In determining who is a family member a supervisor would be required to follow the description of family provided in this report. Further, the supervisor would only be able to deny such leave based on the staffing needs of the affected department. Employees would also have a right to appeal the supervisor's decision.

Employees would be unable to accumulate retirement time while on family care leave because it is unpaid leave. To minimize the loss of accumulating retirement time, the supervisor and the employee should attempt to utilize as much paid leave as possible before switching to unpaid family care leave.

As for the cost of allowing employees to use family care leave, the Federal General Accounting Office conducted a study of the cost of the proposed Federal "Family and Medical Leave Act of 1989." The leave outlined in the Act's provisions is similar to the family care leave which we are proposing. The study of the Federal act concluded that "there will be little measurable net cost to employers associated with replacing workers or maintaining output while workers are on unpaid leave."³⁵ The Task Force would expect that the same would hold true for the City of San Francisco.

2. Sick/bereavement leave

Sick leave is a form of leave which is either paid or unpaid, and can be used by an employee for absence because of illness, medical or dental appointments, quarantine, bereavement, maternity, or child care.

Employees may be absent on sick leave because of the illness, injury, or medical or dental appointment of a dependent child.³⁶ However, such leave is not allowed to exceed five working days in any year. The Task Force recommends making this leave more family-friendly by removing the five day cap. The Task Force recognizes that removal of the cap may result in greater use of sick leave for care of sick children. However, use of this leave will also remove family-generated stress from the employee; any increased cost will be offset by increased employee well-being. As with all sick leave, the employee would be required to provide verification for time which exceeds five continuous working days. The total amount of this leave which could be taken could not exceed the earned sick

leave of an employee. If the employee has to use unpaid leave, and the illness is of a long duration, then family care leave would be appropriate.

Bereavement leave is a form of sick leave which is currently granted to an employee for up to three days due to the death of "an employee's parents, step parents, grandparents, parents-in-law, spouse, sibling, child, stepchild, adopted child, legal guardian, or any person permanently residing in the employee's household," and for no more than one day due to the death of other relatives. Two additional days of leave are given if travel outside of the State of California is required as a result of the death. Bereavement leave can be paid or unpaid, depending upon whether the employee has accumulated paid leave to use.

The Task Force recommends that this language, while now fairly broad, should be further expanded to recognize the diversity of San Francisco's families and to respond to the needs of bereaved employees in a compassionate manner. Not only may an employee be bereaved due to a death in his/her own family, but a person to whom the employee must offer emotional support, such as a spouse or domestic partner, may be bereaved and be in need of the employee's presence at a critical time. Thus, the Task Force recommends that the following bereavement leave policy be adopted by the Civil Service Commission and ratified by the Board of Supervisors:

Bereavement leave of no more than three workdays will be provided due to the death of a family member of the employee, including but not limited to, the employee's spouse or domestic partner, parents, step parent, grandparent, sibling, parent-in-law or parent of a domestic partner, aunt, uncle, child, step child, adopted child, or someone for whom the employee has parenting responsibilities, legal guardian, or any person permanently residing in the employee's household. Bereavement leave of no more than one workday will be provided due to the death of any other person the employee may be reasonably deemed to owe respect.

3. Religious leave

Religion plays an important role in the lives of many San Franciscans and their families; many religious holidays are celebrated together by family members. The City now recognizes Christmas as such a holiday and gives all employees that day off. However, the celebration of other religious holidays, such as Good Friday, Rosh Hashanah, Buddha's birthday, Vietnamese Tet New Year, and Chinese Lunar New Year, may require an employee's absence from the workforce for an entire day or part of a day. Such holidays are not recognized by the City, and City employees must use paid leave to observe them. This can place religiously

observant employees at a disadvantage when compared to less observant employees. It is the view of the Task Force that the ability of City employees to observe religious holidays should be made as easy and as penalty free as possible.

The Federal Government makes such accommodation for its employees under Title V of the Federal Employees Flexible and Compressed Work Schedules Act of 1978 - "Adjustment of Work Schedules for Religious Observances." Under this law, a Federal employee may elect to work compensatory overtime for the purpose of taking time off, without charge to leave, when personal religious beliefs require that the employee abstain from work during certain periods of the work-day or workweek. Any employee who elects to work compensatory overtime for this purpose is granted (in lieu of overtime pay) an equal amount of compensatory time off (hour for hour) from his or her regular work schedule.

The law also provides that under appropriate regulations, an employee's election to work compensatory overtime or to take compensatory time off to meet his or her religious obligations may be disapproved if such modifications in work schedules interfere with the efficient accomplishment of a Federal agency's mission.

The Task Force believes that this law for Federal employees can serve as a model for the City and recommends that the City establish a similar form of leave so that employees may more easily observe religious holidays.

B. Changes in the Provision of Health Care Benefits

1. A system in need of revision

The Health Service System for City employees was established by amendment of the City Charter in March 1937.³⁷ The system is administered by the Health Service Board. The system covers all permanent City employees, including officers of the City and County, employees of the school district and Community College, employees of the Parking Authority, such other employees as may be determined by ordinance, and others as required by state or Federal law. The Board of Supervisors has also provided for membership in the Health Service for employees who are not retired and who have six months or more continuous service, whose normal work week at the time of inclusion in the system is not less than twenty hours. The system currently services approximately 46,000 active and retired City employees and 35,000 dependents.

Members of the system elect to participate in any one of five different plans providing hospital, physician-medical, surgical and other benefits. The City-administered plan (Plan 1) is a fee for service and preferred-provider plan. Under Plan 1 specified basic and major medical benefits are paid by the system to members and health care providers. Under the other plans, benefits are provided through health maintenance organizations (HMOs) or variations thereof. The system's function under the HMO plans is to collect, reconcile and disburse premiums to the various health plan contractors.

The cost of benefits provided by the system is paid by contributions received from City workers and from the City and County. The per-member contribution of the City and County is determined annually in accordance with the Charter.³⁸ The Charter mandates that the City's monthly per member contribution be based on the average contribution of the ten most populous counties in California. The City's monthly per member contribution for the fiscal year 1989-90 is \$122.29, and for fiscal year 1990-91 is \$142.24. Employee member contribution rates are established to pay the difference between the City's contribution and the cost of providing benefits under each of the five plans. Therefore, employee member contribution rates vary between plans.

Unlike most private as well as public health care insurance plans, the City does not pay the premiums for the health insurance of spouses and dependent children of its employees. The City's contribution is for the employee only; employees pay the full cost to provide benefits for spouses and other dependents. Because the City does not pay for employee dependents, the City's annual contribution rate for employees is approximately \$150 less per month per employee than the average of the other ten most populous counties surveyed by the Civil Service Commission. Additionally, this contribution does not include the provision of employer-paid life, disability and dental insurance plans. Typically other employers now pay for several of these types of plans; San Francisco pays for none and offers none.

Because of the City's failure to contribute to dependent care premiums, the current health benefits system for City employees is affected by **adverse selection**. Adverse selection occurs when individuals who are less likely to require medical treatment drop out of a health insurance plan, leaving only those persons who require the most health care remaining in the plan. This situation leads to an upward spiral in premiums and a financial drain on the system because of a decreasing opportunity to pool risk across individuals with differing levels of health care usage.

Under the current health benefits system, City employees must carefully decide, based on economics, whether to cover their dependents. Dependents who have other health insurance coverage (typically through their employer or, in the case of children of the employee, through the employer of the other parent) are not enrolled. Dependents who need health insurance coverage and do not have it elsewhere are enrolled. The result is that 59% of the City's employees are **medically single**,³⁹ and have no dependents enrolled in the system. This is the approximate reverse of the typical employer experience.

The dependents who are currently enrolled in the system (spouses and children) typically require more health care than other dependents, and their average health care costs are higher than those of dependents as a whole. As claims costs increase and the costs of dependent premiums follows, the choice by an employee to continue coverage for each dependent becomes more deeply rooted in the economic decision of measuring premiums to expected health needs and costs. The result is that as dependent costs increase, only the less healthy dependents remain in the system, driving the costs even higher.

The Task Force recommends that the City's health care benefits system for City employees be overhauled, with the long term goal being payment by the City of the premiums for dependent coverage. Even if the City would merely contribute to the cost of providing dependent coverage, as most employers do, then the City would ensure that most or all dependents would have health insurance, costs would be spread out over a larger group of people, and premiums for dependent coverage would be lower. Additionally, more preventive health care would occur, resulting in healthier dependents and the possible avoidance of the costs associated with serious illness. Such a result would strengthen both individuals and families. It would also increase the City's standing as a competitive and attractive employer. Thus, the City and its employees would both benefit if the City contributed to dependent coverage.

Any revision in the health care benefits system would require a Charter amendment. The Task Force recommends that immediate discussions on this issue be held between representatives of the City, employee organizations, health care provider representatives, and other interested parties to consider different approaches to such an amendment.

2. Health care benefits for extended families

The Task Force surveyed City workers to ascertain the health care needs of their families.⁴⁰ For the purposes of this section, **extended family member** means a family member, other than a domestic partner, who is not currently eligible to be enrolled for health insurance under the rules of the Health Service Board. Approximately 12,100 City workers, or 39%, would purchase coverage for an extended family member if the option were available. The survey indicated that a total of

approximately 23,150 extended family members would be covered. Clearly, there is a very great need for this coverage.

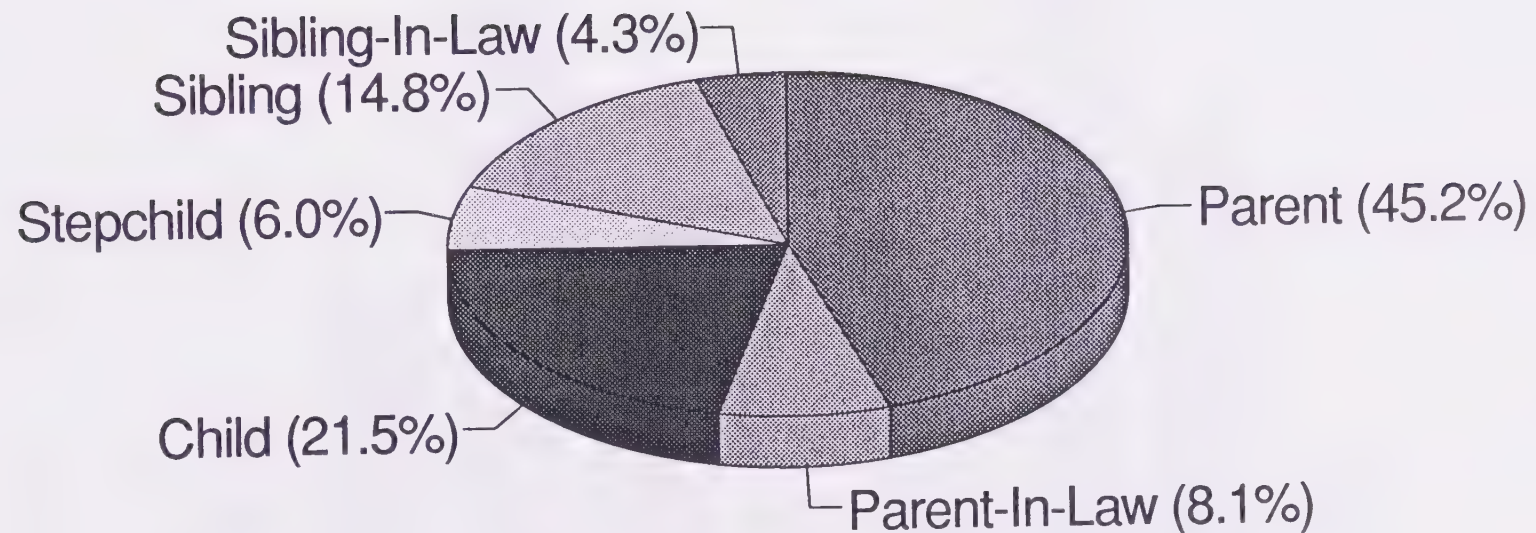
Of the extended family members to be covered, 53% are parents or parents-in-law of the employee, 28% are children or stepchildren,⁴¹ and 19% are siblings or siblings-in-law. These results are presented in Figure 1. The age distribution, presented in Figure 2, shows a large concentration over the age of fifty. Indeed, 51% are fifty or over, and 42% are sixty or over. The City's insurers have indicated that they are not capable at this point of providing health care benefits to the entire group of extended family members. The large concentration of elderly would result in very high average health care costs; if the premium were set high enough to cover that average cost, all but the least healthy would drop the coverage, leading to the upward spiral of premiums characteristic of severe adverse selection.

An additional complication in covering parents of City employees arises from the interplay between employee health insurance and the federal Medicare program. If an active City employee were to enroll an extended family member who is eligible for Medicare, the City plan would become the primary insurance coverage, with Medicare secondary. In other words, the City plan would pay all the medical bills, subject to certain limits, deductibles and copayments; Medicare would pay a portion of the expenses not covered by the City plan. By contrast, health insurance provided to the dependents of retired City employees is secondary to Medicare. Thus, if active City employees were to place older family members, such as parents, on a City plan, there would be a large transfer of costs from Medicare to the City, with limited benefit to family members. Medicare supplements (medigap insurance) are available from commercial insurers, including those who contract with the City. The City should inform employees with elderly extended family members of the availability of these outside policies.⁴²

Thus, we conclude that it is not feasible for the City to provide health care benefits to all extended family members at this time. However, it is feasible to provide coverage to many children or stepchildren of City employees who are currently excluded. The excluded children fall into two groups. The larger group, approximately 5,000 in number, have lost eligibility for City insurance because they exceed the age limit for coverage of dependent children. These adult children are heavily concentrated in the age group 19-29; in the sample, none were over 40 years of age. The remaining 1,350 children lack the requisite legal relationship to qualify for coverage under the employee's City health insurance: approximately 560 were the children of the employee's spouse, while 735 were children of the employee's domestic partner. The age distributions of these adult children and "unrelated" children are presented in Figure 3.

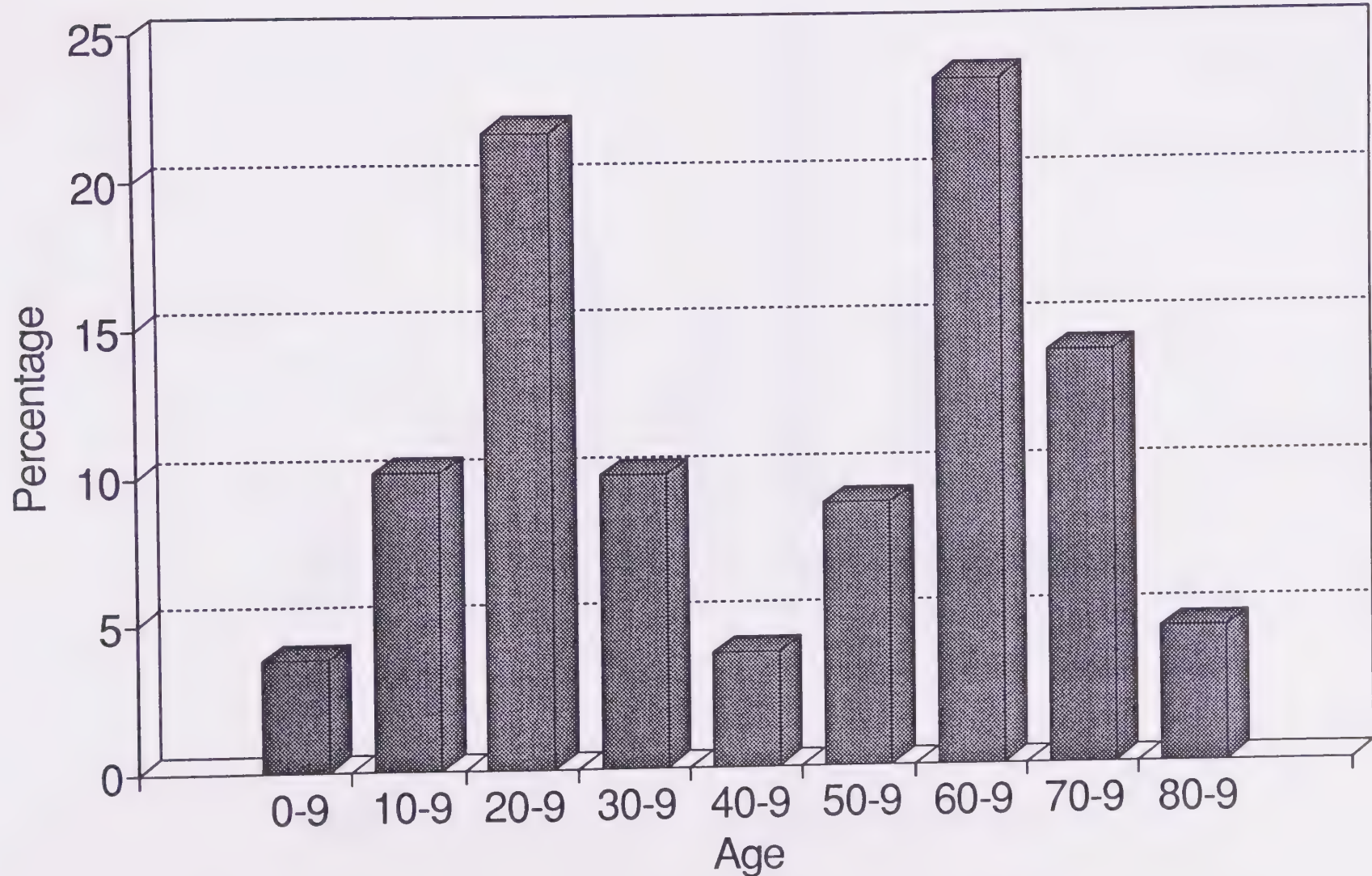
Categories of Extended Family Members

Figure 1



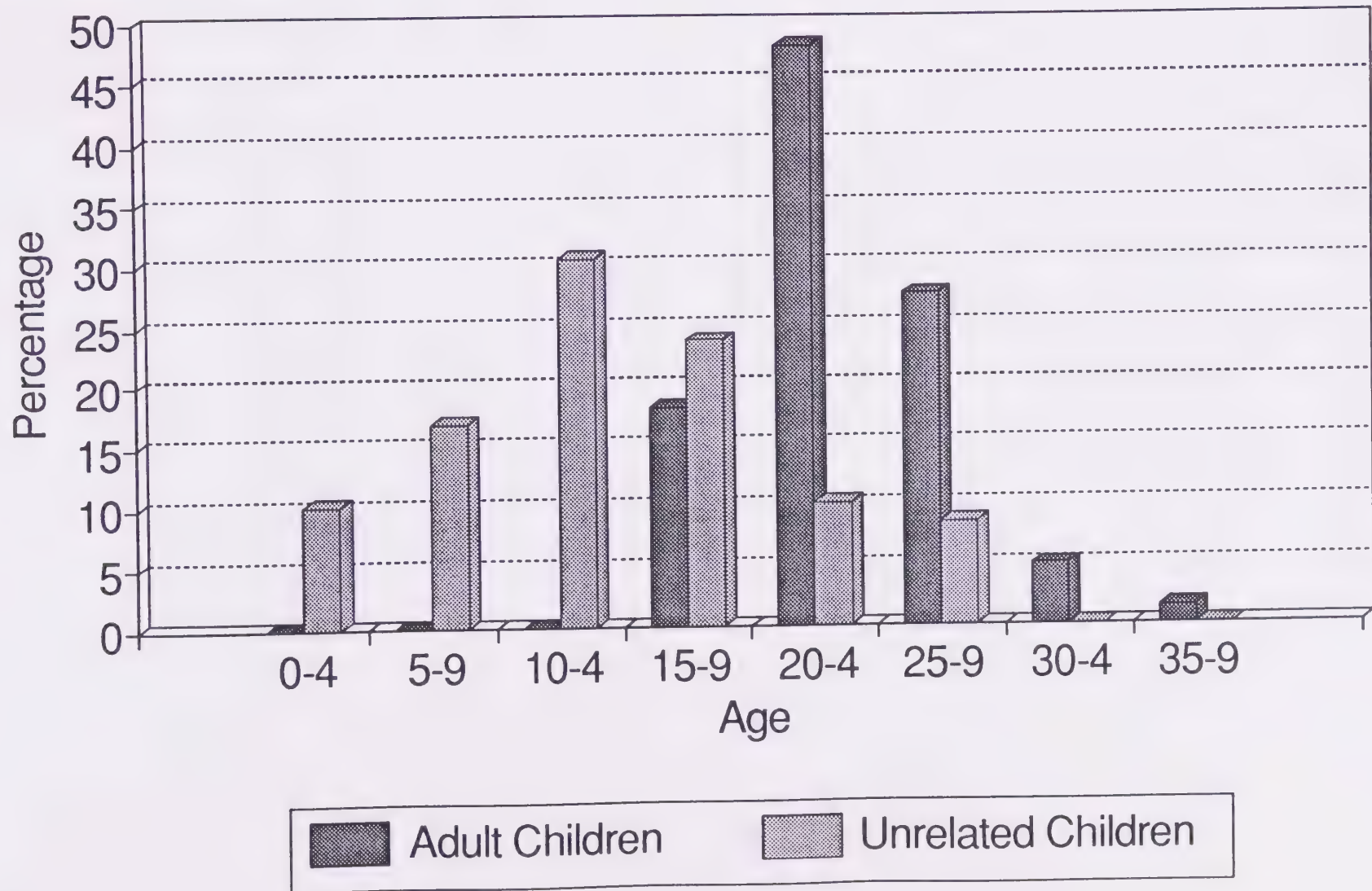
Age Distribution: Extended Family

Figure 2



Age Distribution: Noncovered Children

Figure 3



The number of adult children seeking coverage is surprisingly large. The only possible explanation is that these young adults are predominantly employed in entry-level jobs that do not provide health insurance coverage. The children who pose the greatest risk of high claims, those who suffer from physical disabilities, do not lose their eligibility as they age; accordingly, most are already covered under the current plan.

The current premium structure is one key reason that insurers have been reluctant to cover adult children in the past. The premium received by the HMOs for two adults and any number of children is less than three times the premium for one adult. In other words, the first child is subsidized and subsequent children are free. It would be unfair to the HMOs to continue coverage to adult children using this premium structure as the parents enter middle age, with attendant higher health care costs.

However, the survey indicated that employees were willing to pay the full adult premium for the 5,000 adult children for whom coverage was desired. The age distribution of this pool should make them an attractive risk group, even given a certain amount of adverse selection. The City's HMOs have expressed reluctance to include all of these children immediately, but are willing to include those up to age 24 for an additional premium equal to the rate for single adults. As a first step toward providing coverage for this group, the Task Force recommends that a new category of eligible dependent be created, to include

the natural or adopted children of the employee or of the employee's spouse or domestic partner, aged 24 or under.

The premium would be paid by the employee. Of course, children eligible under the existing categories would continue to be covered under the existing favorable premium rates. From the survey results, we estimate that 3,300 adult children of City employees would be enrolled under this provision. We recommend that the program be reviewed after two years to determine if it is feasible to raise the age limit from 24 to 29.

The large number of "unrelated" children excluded from coverage is also surprising. The Health Service System rules currently provide that

A child living with [the employee] in a parent-child relationship and economically dependent on [the employee], age 18 or under, who has never been married is also an eligible dependent provided the [employee] declares the dependent as an exemption on his or her income tax.

The Task Force was informed by the Health Service System that coverage is extended to the children of the domestic partner or spouse of an employee under the above rule. However, the survey results make it clear that a large number of employees either misunderstand the intent of the provision or cannot meet the test of declaring the child as an income tax exemption. Accordingly, the Task Force recommends that the above rule be amended to read

A child living with [the employee] who is economically dependent on [the employee], age 18 or under, who has never been married, is also an eligible dependent.

and that the following rule be added:

The natural or adopted child of the spouse or domestic partner of the employee, age 18 or under, who has never been married, is also an eligible dependent provided that the spouse or domestic partner is enrolled in the health insurance plan.

The HMOs which serve City employees are agreeable to these changes.

Most of the "unrelated" children are age 18 or under, but approximately 20% are over age 18. We believe that almost all of the 1,350 "unrelated" children would qualify for coverage under one of the two rules just stated or the proposed rule for adult children. As a consequence, we estimate that a total of 4,650 children would receive health care coverage as a consequence of the changes recommended in this section.

3. Health care benefits for domestic partners

The extension of benefits to domestic partners is economically feasible for the City and its insurers. The cities of Berkeley, West Hollywood, and Santa Cruz have provided health insurance to domestic partners for some time without any undue financial effect. A similar program went into effect in April 1990 in Seattle. The issues underlying health insurance for the domestic partners of City employees differ from those underlying health insurance for extended families. The Task Force is in agreement that the extension of health benefits to domestic partners is an equalization of currently provided benefits, i.e. the provision of equal pay for equal work to similarly situated persons, whereas the provision of health care benefits to extended families would be a new benefit for all workers.

The Task Force surveyed active City employees to estimate the number of domestic partners who might be enrolled for health insurance.⁴³ The survey form was drafted by a subcommittee of the Task Force, reviewed by several faculty in the Economics Department at UC Berkeley, and tested on a sample of 100 City employees to ensure that the questions were clear and the results would be mean-

ingful. The survey was mailed to 4,568 City employees in January, 1990. Two follow-up postcards were sent to encourage a high response rate. 1,620 surveys were returned, a response rate of 35.5%; this is considered quite good for a survey of this kind.

Our calculations are based on a workforce of 31,000 active City employees.⁴⁴ The survey indicates that 3701 City employees (11.9%) have a domestic partner. Of these, 2104 (6.8%) would enroll their domestic partner for health insurance. In both cases, the margin of error is 1.2%.

The domestic partners who would be enrolled break down as follows:

<u>Employee</u>	<u>Partner</u>	<u>Number</u>
Male	Male	594
Male	Female	548
Female	Male	450
Female	Female	512

The margin of error in each category is 0.6%. Of the domestic partnerships, 28% are gay men, 24% are lesbians, and 47% are heterosexuals.

At first sight, the number of domestic partners who would be enrolled for health insurance may seem small, given the large size of the lesbian and gay male community in San Francisco. A number of factors contribute to this. First, the survey only counted gay male and lesbian employees who are in domestic partnerships, not the total number of gay male and lesbian employees. Second, the City workforce is drawn from the entire Bay Area, and not just from San Francisco; the proportion of lesbians and gay men in counties outside San Francisco is presumably lower than in San Francisco. Third, a significant proportion of gay male and lesbian City employees who are involved in domestic partnerships may be unwilling to state this fact to their supervisors.

The City's insurance providers are amenable to the extension of health insurance to domestic partners, provided that the enrollment procedure ensures that the relationship is a true domestic partnership. Thus, the Task Force recommends that the employee and his/her domestic partner be required to file a sworn affidavit with the Health Service Board. The affidavit would include the following statements by the partners:

- they live in the same household;
- neither partner is married, nor does either partner have another domestic partner;
- they are both 18 years of age or older;

- they are not related by blood to one another closer than would bar marriage;
- they share the common necessities of life;
- each partner will be liable to third parties for any obligations incurred by the other partner for the common necessities of life, defined as food, shelter and medical care.

The obligations and financial responsibilities embodied in the affidavit are exactly the same as those assumed by husbands and wives under California law. The employee would be allowed to enroll a domestic partner for health insurance only during an open enrollment period. If an employee terminated a domestic partnership, there would be a waiting period of six months before the employee would be eligible to enroll another domestic partner for health insurance. The insurers are satisfied that these conditions will ensure that only true domestic partners are enrolled for insurance.

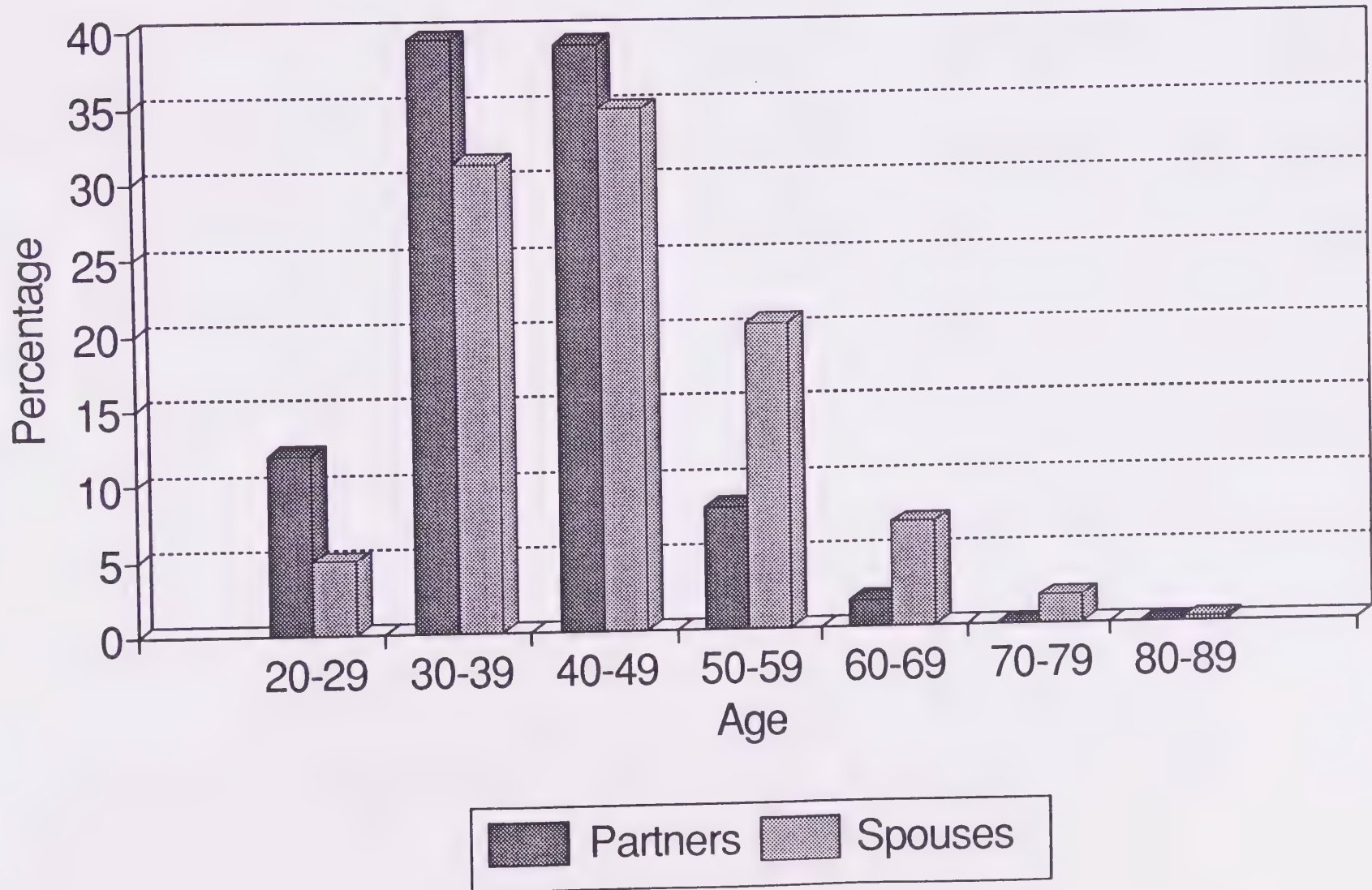
It is quite possible that the claims experience among domestic partners will be more favorable than that among spouses currently enrolled in the plan. The survey revealed that the domestic partners are substantially younger as a group than the spouses of City workers: for example, 29.3% of the spouses are at least fifty years old, while only 9.7% of the domestic partners are in the same age category. The age distributions of spouses and domestic partners are presented in a bar graph in Figure 4. The younger age of the domestic partners would tend to produce a lower level of utilization of health care services.

There will, of course, be some cases of AIDS in this group. Among the 2104 domestic partners to be enrolled, the predicted number of new cases of AIDS each year is 18. To put that in perspective, in a random sample of 2,100 male San Franciscans aged between 18 and 64, the predicted number of new AIDS cases annually would be 14. Thus, the predicted number of AIDS cases among the domestic partners is little different from that to be expected from a random sample of adult male San Franciscans. It is estimated that a total of 38 domestic partners will be taking AZT at any time. The methodology and calculations underlying these estimates are presented in Appendix D.

Adverse selection will play some role within the group of domestic partners. However, in order to enroll a domestic partner for health insurance, a City employee will have to assume the same financial obligations assumed by married couples. In particular, the City employee will become liable for food, shelter and medical care for the domestic partner; employees will be unwilling to assume this obligation for mere friends, just as they would be unwilling to marry a mere friend in order to provide health insurance. Heterosexual domestic partners have always had the option of securing health insurance coverage by marrying, and it is likely that a large number have done so. Moreover, heterosexual domestic part-

Age Distribution: Spouses vs. Partners

Figure 4



ners have always had the option of falsely claiming they were married to obtain health insurance coverage; the survey indicated that 0.9% of City employees, or about 293 employees, are currently doing so. To the extent that heterosexual domestic partners have chosen to marry or falsely claim marriage in order to obtain insurance in the past, the degree of adverse selection among newly enrolled heterosexual domestic partners would be reduced compared to the degree of adverse selection among spouses.

Nonetheless, the extension of coverage to domestic partners presents the insurers with additional uncertainty, and they have understandably sought to have the City share the risk in the event of unfavorable claims experience. When Kaiser first offered domestic partner coverage to employees of the City of Berkeley, it imposed a surcharge of \$2.00 per enrolled employee per month; in the light of their experience, this surcharge was reduced in stages to \$0.70, and then completely eliminated as of July 1, 1989. In order to allay the concerns of the insurers about the increased uncertainty, we recommend that the City share the risk (as well as the benefit in the event of favorable claims experience) for a limited period of time. Once the HMOs have enough claims experience, they should bid for the City contract based on their experience among City employees and dependents as a whole.

Of the Health Maintenance Organizations which serve City employees, only one (Kaiser) has had significant experience covering domestic partners of subscribers. However, Kaiser's experience is limited to the City of Berkeley. Because of their limited experience, the insurers expressed concerns over their ability to estimate the utilization of health care by domestic partners, and thus to determine an appropriate premium for coverage.

The three principal HMOs serving City employees are Kaiser, Bridgeway and Bay Pacific. These three HMOs, along with the City's self-insured indemnity Plan 1, cover 95% of all active City employees. Bridgeway and Bay Pacific expressed concerns over the possibility of adverse claims experience as a result of HIV-related costs. Kaiser's concerns were quite different. Kaiser has extensive data on its health care costs by age and sex, and in particular has extensive data on health care costs related to HIV infection. Based on its data, Kaiser has determined that HIV-related costs among domestic partners will not present a serious problem. However, the survey indicated that domestic partners would be disproportionately in the prime child-bearing age cohort, and Kaiser expressed fears that costs associated with pregnancy and childbirth would result in adverse claims experience within the group. All three HMOs expressed some concern that the provision of insurance to individuals who were previously uninsured would result in a short-term rise in elective care, which would disappear over time.

Kaiser's situation is quite different from that of Bridgeway and Bay Pacific. San Francisco City employees make up a substantial portion of Bridgeway's and Bay Pacific's memberships, but only about one per cent of Kaiser's, so that the relative impact of offering domestic partner coverage to City workers is higher for Bridgeway and Bay Pacific. Kaiser is self-insured, while Bridgeway and Bay Pacific purchase reinsurance; thus, Kaiser is free to contract for domestic partner coverage, while Bridgeway and Bay Pacific must obtain the approval of their reinsurers. Bridgeway and Bay Pacific are willing to allow auditing of the claims experience among domestic partners; Kaiser has long regarded its cost data as proprietary, making such auditing impractical.

The Task Force has reached agreements with Kaiser, Bridgeway and Bay Pacific on the terms of domestic partner coverage. It recommends that the Health Service Board execute Memoranda of Understanding with the HMOs to enact these agreements. Because of the differing concerns and situations of the HMOs, the agreement with Bridgeway and Bay Pacific is different from the agreement with Kaiser.

The Task Force has also been informed that Health Net, an HMO with whom the City does not currently contract, is willing to provide domestic partner coverage and is eager to bid for the City contract for the plan year beginning July 1, 1991. Health Net has indicated that it would bid on a basis similar to Kaiser.

Features Common to the Two Agreements:

Domestic partner coverage will take effect July 1, 1991, with open enrollment taking place during May, 1991. In the event that the effective date is delayed beyond July 1, 1991, all dates referred to in the agreements will be postponed by the same length of time. All three HMOs will provide coverage to the domestic partners of active employees only; retired employees may not cover domestic partners at this time.⁴⁵ The Task Force views the restriction to domestic partners of active employees as a transitional arrangement. Once experience is gained with domestic partners of active employees, the City and its insurers should negotiate terms for coverage of the domestic partners of retirees.

Both agreements involve a sharing of risk between the City and the HMOs. Thus, the City and HMOs will share the cost in the event of adverse claims experience, and share the benefits in the event of favorable claims experience. The exact manner in which the risk is shared is different in the two agreements, but both agreements are designed to give the HMOs incentives to control costs. The payments and risk sharing prescribed by the two agreements will begin on the date domestic partner coverage is effective.

If the experience covering domestic partners is consistent with expectations, the HMOs will bid for the City contract beginning July 1, 1993 based on their claims experience for dependents including domestic partners. From that point, the HMOs will bear all risk for adverse claims experience, and there will be no special loading for domestic partners.⁴⁶

The Agreement with Kaiser:

Kaiser will provide health insurance coverage to the domestic partners of active City employees. A loading factor of \$3.01 per active employee per month will be paid by the Health Service Board starting on the effective date of coverage. Kaiser will assume all risk for adverse claims experience and will reap any benefits of favorable claims experience through June 30, 1992.

Based on the claims experience among domestic partners through September 30, 1992, Kaiser will adjust the loading factor up or down on January 1, 1993. The Health Service Board may, at its option, defer part or all of the adjustment until July 1, 1993. If the Health Service Board exercises this option, any adverse experience in the period July 1, 1992 to June 30, 1993 which is not recovered by the adjustment shall be recovered through a back-loading in the period July 1, 1993 to June 30, 1994.

Kaiser is currently moving from Community Rating, in which the same premium is charged to all employers, to Adjusted Community Rating in which the charge to each employer is determined by the claims experience among that employer's employees and their dependents. The amount by which the premium is adjusted each year is capped. In the event of adverse claims experience among the domestic partners of City employees, the adjustment may exceed the cap by an amount sufficient to reflect that adverse experience.

As noted above, Health Net has indicated a desire to bid for the City contract on a similar basis. The details of their bid, including the size of any loading factor, will be determined when their bid is submitted for the plan year beginning July 1, 1991.

The Agreement with Bridgeway and Bay Pacific:

Bridgeway and Bay Pacific will provide health insurance coverage to the domestic partners of active City employees. A loading factor of \$3.00 per active employee per month will be paid by the Health Service Board starting on the effective date of coverage.

Each HMO will track its HIV-related costs among the domestic partner group. The definition of HIV-related costs involves some technical issues which need to be resolved in further negotiations among the Health Service Board, Bridgeway and Bay Pacific.

Each HMO will report its domestic partner HIV-related costs to the Health Service Board. The HMO and the Health Service Board will agree on a mutually acceptable timetable for, and means of auditing, these reports. Before being submitted for audit, any information which could identify the individual should be removed, in conformity with state law on the disclosure of HIV test results.

In the event that the HMO's domestic partner HIV-related costs are less than \$3.00 per month per active City employee enrolled in the HMO, the difference shall be returned to the City. In the event that the HMO's domestic partner HIV-related costs exceed \$3.00 per month per active City employee enrolled in the HMO, the difference shall be covered as follows:

- any amount between \$3.00 and \$4.00 per month per enrolled active City employee shall be borne by the HMO;
- any amount between \$4.00 and \$8.00 per month per enrolled active City employee shall be shared equally by the Health Service Board and the HMO;
- any amount exceeding \$8.00 per month per enrolled active City employee shall be borne by the Health Service Board.

Other HMOs:

The City contracts with certain other HMOs, but the number of employees enrolled in these HMOs is quite small. In some cases, these HMOs serve City employees whose worksites are far from San Francisco. We recommend that the Health Service Board request that each HMO submit its bid for the plan year beginning July 1, 1991 based on whichever of the two agreements outlined above the HMO prefers.

City Plan 1:

In addition to the HMOs, the City offers a self-funded, self-administered fee-for-service plan. Since Kaiser is willing to take the full risk of any adverse experience among domestic partners for the first year for a loading fee of \$3.01 per month, we are confident that the burden on City Plan 1 will not exceed the same rate.

Total Cost of Domestic Partner Coverage:

Under the Charter, premiums for dependent coverage are paid by the employee. We recommend that the premium charged to the employee to cover a domestic partner be the same as the premium charged to cover a spouse.

As we have noted, it is entirely possible that the claims experience among domestic partners enrolled will be more favorable than that among spouses. In this event, after the phase-in period covered by the agreements with Kaiser, Bridgeway and Bay Pacific, the premiums paid by employees for domestic partner coverage will more than cover the cost of the health care services provided, providing funds that can be used to subsidize other dependent coverage.

In the first year, however, the agreements provide for payments by the Health Service Board to the insurers. The payment to Kaiser is fixed, while the payments to Bridgeway and Bay Pacific depend on their experience with HIV-related claims.

In Appendix D, we provide estimates of the expected payments by the Health Service Board in connection with these agreements. The expected payment by the Board to Bridgeway and Bay Pacific is estimated at \$2.71 per active employee per month. Under extremely pessimistic assumptions about the degree of adverse selection among domestic partners and the rate of AZT usage, the expected payment rises to \$3.22 per active employee per month.

We emphasize that all of our calculations are actuarial values. Since the actuarial number of AIDS cases among domestic partners is small, random fluctuations could result in a higher or lower number of cases. The actuarial number of new AIDS cases among domestic partners of City workers enrolled in Bay Pacific or Bridgeway is 3.8 per year.⁴⁷ Because this number is so small, the statistical margin of error is comparatively large: 3.9. In other words, with 95% probability, the number of new AIDS cases per year among domestic partners enrolled with Bridgeway and Bay Pacific will be between 0 and 8, with 4 being the actuarial value. Consequently, the domestic partner HIV-related costs could also show random fluctuations; the figures we have presented are actuarial values, or averages.

Using the \$3.00 figure, the cost to the Health Service System would be \$1,116,000 for the 1991-92 fiscal year. The City's contribution to the Health Service System is set by the Charter at the average contribution for employee health care coverage (excluding dependents) of the ten most populous counties in California. This figure exceeds the premium charged the Health Service Board by the HMOs, and the difference has long been placed in a pool to subsidize the cost of dependent coverage. This pool now contains over 7 million dollars. We recommend that the cost in the first year be paid out of this pool. As a consequence, there

will not be any additional demand on the City general fund, nor will there be any increase in the out-of-pocket premiums paid by employees.

C. The Retirement System

City employees belong to one of four separate pension plans, depending on the department in which they work and the date on which they were first employed by the City. The details of the provisions differ from one plan to another, but all are administered by the Retirement Board.⁴⁸ The Task Force has identified certain policies common to all the plans which it has determined are discriminatory against domestic partners.

When a retired employee dies, 50% of the pension⁴⁹ payment is automatically continued to a qualified⁵⁰ spouse until the spouse dies or remarries. This continuation benefit is provided automatically, without any actuarial adjustment to the employee's pension benefit. By contrast, if an employee with a domestic partner dies, there is no automatic continuation benefit to the surviving domestic partner. The employee may, at the time of retirement, designate any other person as a co-annuitant to receive a continuation benefit. If the employee does so, however, the employee pays for the designation by accepting a reduced pension. Thus, the employee must pay for the continuation benefit to a co-annuitant such as a domestic partner, while the continuation benefit for a qualified spouse is provided at no charge.

If the employee who is eligible to retire dies prior to retirement, the plan acts as if the employee had retired, then died immediately thereafter. As a consequence, a qualified spouse receives a 50% continuation benefit until the spouse dies or remarries. Any other beneficiary receives only a return of the employee's own contributions, plus interest. The nonspouse beneficiary receives no benefit from the City's contributions to the pension plan on behalf of the employee.

Eliminating this discrimination is, in a sense, easier to eliminate than the discrimination in the provision of health benefits. The principal concern in health insurance is adverse selection due to the possible overrepresentation in the membership of individuals who will need health care. In the case of pensions, it is the individuals who are more healthy who are more expensive, since they are likely to live longer and thus draw their pensions over a longer period. The Task Force found that adverse selection is not a problem with pensions as opposed to health or life insurance. Thus, the City's current plans allow each employee to name anyone as a co-annuitant, with an actuarial reduction in the pension based on the ages of the employee and co-annuitant. Commercially available annuities have similar provisions.

The Task Force believes that the City pension plans should treat domestic partners in the same way spouses are currently being treated. Thus, the qualified domestic partner of a City employee who died while retired or eligible to retire would be eligible for a 50% continuation without any actuarial reduction in the employee's pension. The continuation benefits to both spouses and domestic partners would continue until the recipient died, married or registered a new domestic partner. Employees would designate an individual as his/her domestic partner by executing an affidavit similar to that which the Task Force is recommending be used to obtain health care coverage for domestic partners.

The Task Force additionally recommends continuing the pension beyond the remarriage of the spouse or domestic partner. The present practice of eliminating the continuation benefit upon the remarriage of the widow or widower imposes a severe financial penalty against the formation of families.

Changing the pension plans to accommodate domestic partners and eliminate the remarriage penalty will require a Charter amendment. Such an amendment must be carefully drafted to recognize the differences among the four plans, and to ensure compliance with Federal and California laws. A new survey of City employees and a detailed actuarial analysis will be needed to estimate more precisely the potential fiscal impact on the City. Because this process is quite complex, the Task Force recommends that the Mayor establish a new task force specifically to address the pension issue.

D. MUNI Passes

The San Francisco Municipal Railway (MUNI) is a department under the Public Utilities Commission.⁵¹ MUNI currently provides free dependent transit passes only to the spouses and dependent children under 19 years of age of a specific group of its employees,⁵² provided that the spouse is living with the employee and the dependent children are also living with the employee or receive a major portion of support from the employee. The Task Force recommends that this policy should be expanded and made more family-friendly by extending dependent transit passes to other family members living in the same household, such as domestic partners, parents, and children for whom the employee has parenting responsibilities.

E. Other Family-Friendly Policies

1. Modification of standard work rules

During the October 17, 1989, earthquake, Bay area employers discovered the effect which time schedules can have on employee transportation during a time of emergency. The use of flexible scheduling (flexitime) is a device which can beneficially affect work-related commuting patterns, as it varies the arrival and departure times of employees. It is estimated that 13 percent of organizations employing 50 or more employees have flexitime. Moreover, flexitime, as well as other alternative work arrangements such as job sharing,⁵³ flexplace work,⁵⁴ and reduced hours⁵⁵ can serve as a catalyst in promoting family life and aiding employees in dealing with family problems. Thus, the Task Force recommends that the City be more aggressive in its implementation of these modifications to the standard work rules and policies. The Task Force is, of course, mindful that City departments need to be staffed during key work hours to ensure that the obligations of the departments are met, but flexible programs have been used effectively in both the private and public sectors. Managers must be taught that not all work needs to be done "8-to-5," not all work needs to be done at the job site, and not all employees must work full time.

2. Child care

By the year 2000, almost half the employees in the nation's work force will be providing child care, elder care, or both.⁵⁶ The provision of these types of care should now be of immediate and critical concern. In assessing all of the potential predictors of psychological adjustment at home or on the job, it has been found that the breakdown of child care arrangements ranks as one of the most significant. In a nationally representative study of 405 employed mothers and fathers, conducted for Fortune magazine, the breakdown of child care arrangements was linked to higher levels of stress.⁵⁷

The advantage to employees of on-site day care is that reliable child care is available near the workplace and at hours which accommodate work schedules. Because the children are close at hand, parents can visit children during the day, feel more assured about their care, and respond quickly in emergencies. A result of providing such care is improved employee morale and performance. On-site child care also provides other benefits such as lower employee turnover, lower tardiness, lower absenteeism, and shortened maternity leave.⁵⁸ These benefits are cost savers to the City. For example, the high absentee rate among Parking Control Officers is due to problems with child care.⁵⁹ On-site child care is therefore cost effective as well as family-friendly.

The Task Force recommends the expansion of affordable, quality on-site child care for preschool children of City employees. The first child care facility at a City agency, the City Attorney's Office, opened only recently. On-site child care

is planned for nurses at General Hospital and Laguna Honda Hospital, at San Francisco International Airport, and as a pilot program for MUNI operators. The Task Force recommends that all City and County agencies and/or departments provide affordable, quality on-site child care for their employees.

In addition to on-site child care, employees should be provided information about financial assistance for off-site child care and the availability of after school programs for school age children. The Office of Employee Benefits, which the Task Force is recommending be created, can serve as a central clearinghouse for this information.

Examples of financial assistance for child care include subsidies for family day care, discounts for employees at commercial day care centers, vouchers for employees to use for the child care facility of their choosing, and pretax salary reduction or flexible benefits that include child care (Dependent Care Assistance Plans, or DCAP). The Task Force is pleased to note that the City is planning to institute a DCAP program for City employees on July 1, 1990. Under this plan, the amount contributed by the employee on a pretax basis is held in a special account and used to reimburse the employee for eligible dependent care expenses. Several changes in the City's Administrative Code are still needed to make the plan operational; the Task Force urges the Board of Supervisors to move quickly on these changes.

Another type of child care which has developed across the country in recent years is a program which cares for mildly ill children or **sick child care**. Almost all models exclude children with a high fever or serious illness, and most programs exclude children with infectious diarrhea and highly contagious diseases such as chicken pox. Child care programs for sick children cannot serve parents for all the days a child is sick, but the programs can provide an alternative for days when a child is mildly ill. By providing a sick child care program rather than forcing employees to stay home with a child, the City could save the cost of replacement workers or lost work time. The various models of sick child care include care at a center which provides only that service, care at a hospital, care at a child's regular child care center, and care provided by in-home providers.⁶⁰ Such a program could be established in cooperation with private sector companies. For example, in Tucson, Arizona, the city has joined the Tucson Electric Power Company, the University of Arizona and other employers to subsidize the cost for employees to have in-home care of sick children.⁶¹

2. Elder care

Elder care is imposing pressures upon employees which are similar to those imposed by child care. While the need for elder care assistance is less well publicized than the need for child care, it is no less emotionally and financially debilitating to family members. A 1982 long term survey sponsored by the United States Department of Health and Human Services found that the vast majority of

services to the elderly are provided by families, not by government or private agencies.⁶² Another survey, of employees of the Travelers Insurance Company, revealed that one in five workers over the age of 30 has been providing some degree of care for an elderly parent for at least 10 hours a week, for an average of 5.5 years.

Elder care responsibilities, like child care responsibilities, can result in increased employee stress and decreased productivity.⁶³ In addition, many female employees, particularly in lower paying clerical positions, may have to quit the workforce in order to care for elderly parents.⁶⁴ The possibility of on-site elder care combined with day care for children should be explored. Pilot programs of this nature already exist in the private sector.⁶⁵

San Francisco is also home to the San Francisco Adult Day Health Network, a consortium of seven adult day health care programs which have worked collaboratively since 1983 to serve the City's elderly and disabled adults. The programs allow elderly and disabled persons to live at home, while getting daily medical, rehabilitative, nutritional, and social services they need at a non-profit center in their community. It also relieves the stress on the family members who are responsible for their care at home. The Task Force recommends greater use of this existing network by City employees.

The City government can also utilize its own resources and expertise to establish a information and referral system to deal with the issues of child care and elder care. This system can alert and direct employees to available community-based resources and can be administered by the proposed Office of Employee Benefits.

III. Implementation

The Task Force's recommendations regarding the City of San Francisco as an employer are meaningless unless they are implemented effectively. Management must be trained so that all managers are informed both about these changes and about their philosophical underpinnings. Managers should also be sensitized about the diversity of family structures found in the City, and the responsibilities and pressures which family issues impose upon City workers. Finally, City employees must be made aware of changes in policies and benefits, so that they are equipped with the necessary knowledge to work out their own solutions to family problems.

The Task Force recommends the creation of an Office of Employee Benefits to serve as a centralized place to advise employees of the options which are open to them with regard to benefits. In addition, this department could coordinate and expand employee assistance programs (EAPs) beyond drug or alcohol abuse counseling to include counseling on emotional problems, stress, job termination, career planning, financial planning, retirement planning, and all the life cycle issues which an employee faces. Such programs have been proven to be cost effective:

for every dollar employers invest in EAPs, they recover an estimated \$3 to \$5 from loss which would have resulted from employee problems.⁶⁶ The Office of Employee Benefits could also serve as a clearinghouse and information and referral service about organizations which specialize in family issues.

THE CITY OF SAN FRANCISCO AS A PROVIDER OF SERVICES

The Task Force recommends that, as with the City's employment policies, the City's policies and practices in delivering services to the people of San Francisco should be family-friendly. By not serving the needs and addressing the problems of all the people and families of San Francisco, the government disadvantages the people and families it was intended to serve.

I. Payments to Relatives as Foster Parents

The State of California and the Federal Government together provide Aid to Families with Dependent Children-Foster Care (AFDC-FC). Payments are made to the caregivers of children in need of 24 hour out-of-home care whose own families are unable or unwilling to care for them, and who are in need of temporary or long term substitute parenting. Children are placed with relatives (40% of those placed) or other persons who have been licensed to provide foster care.⁶⁷ The child must meet a Federal eligibility requirement in order to receive payments from the AFDC-FC program. If the Federal eligibility requirement is not met then the foster care provider will not receive AFDC-FC payments. In order to alleviate this eligibility problem, foster care payments are also made out of a state-run foster care program.

A serious problem exists with the state-run foster care program because the program will not make foster care payments to relatives. Thus, in cases in which the Federal eligibility requirements are not met and relatives are providing foster care, the relative caregivers would be eligible only to receive AFDC payments, not foster care payments. The AFDC payments are lower than foster care payments, placing a financial strain on relatives who are foster care givers. This policy is destructive to the family structure; it is particularly detrimental to African-American families, in which it is not unusual for relatives such as grandparents to care for children.⁶⁸

The Task Force encourages the City to lobby for passage of Assembly Bill 1060, which will allow payments from the state-run program to be made to relatives. The Board of Supervisors has already approved a resolution urging this same action, and the bill, which was passed by the Assembly, is currently pending before the Senate Health and Human Services Committee.

II. Emergency Foster Care in Case of a Crisis

Currently, if a child who lives with a biological parent and a domestic partner qualifies to enter the foster care system administered by the Department of Social Services (DSS) as the result of a serious accident or incapacitating illness of his/her biological parent, DSS cannot simply return the child home to the domestic partner for such care. A domestic partner does not automatically qualify to be a

foster parent of a child for whom he/she has parenting responsibilities, as the domestic partner is not recognized as being a relative of the child.

A permanent solution to this problem can only occur on the state level, so that domestic partners are recognized as being part of the child's family and thus automatically qualify to provide foster care to the child. The Task Force recommends that the city lobby for such change. In the interim, DSS recognizes that there are ways to overcome this problem. For example, the domestic partner may have been legally designated as guardian of the child. If such designation has not occurred, then DSS will look to a nomination of guardianship or other expression on the part of the incapacitated parent that the domestic partner should take care of the child. DSS will then license the domestic partner to perform foster care and will perform an immediate home study to facilitate the license.⁶⁹ The domestic partner would then have the legal authority to provide essential care, such as authorizing medical care for the child. Such placement could still be challenged by other relatives of the child.

III. Foster Care Placement Issues

In June 1988 there were a total of 2,640 children in foster care in San Francisco, of whom 1,790 (68%) were African-American. The policy of the Department of Social Services (DSS) and the state is that whenever possible, children will be placed in foster homes with racial and ethnic backgrounds which are similar to those of the children. Unfortunately, this policy has not been followed when children are placed out of San Francisco County, which more than 40 percent of the City's foster children are.⁷⁰ Often, African-American children are placed with White foster families outside the county; in such circumstances, the children may lose touch with their ethnic and cultural heritage. This policy is also destructive of African-American families in San Francisco for another reason: many of the children are placed in homes so far away, or so inaccessible by public transportation, that it is difficult for their relatives to visit them. In these cases, family ties cannot develop naturally and may become strained or even broken.

There are many ways to overcome this problem, and the African-American Task Force for Children has already made many recommendations. DSS has said that it is moving to implement these recommendations as rapidly as possible. The Task Force is concerned with the pace of this implementation - action is needed now.

The Task Force recommends that DSS, perhaps in conjunction with the Department of Public Health, actively pursue prevention of and alternatives to out-of-home placement of children, as well as programs and services which promote the preservation of families, particularly in minority communities. Such programs and services include drug treatment programs, parenting training, respite care, and intensive family supervision. In its 1990-91 budget, DSS has made a special

request for \$500,000 for foster care prevention programs which are especially targeted to the needs of children, and the Task Force urges that this full amount be approved.

Barring a dramatic reduction in the number of children needing foster care, DSS should also hire additional personnel as soon as possible to actively recruit new foster parents from San Francisco's African-American community. The Task Force understands that DSS is short-staffed, but the foster care situation is so critical that additional personnel should be hired as soon as possible. The Task Force is encouraged by DSS' recent hiring of two additional full time recruiters. However, despite these additional recruiters, potential foster parents were recently told that classes for foster care training would not be held for several months. There are many African-Americans qualified to be foster parents; DSS needs to recruit them aggressively in a culturally sensitive manner, and to train them as soon as possible.

DSS has indicated its sensitivity to the out-of-county placement of African-American children, and will now authorize out-of-county placement only upon documentation that no appropriate placement resource in the City could be located for a child within a reasonable time frame after a good faith effort. This policy change is a step in the right direction; it does not, however, alleviate the fact that DSS must recruit sufficient African-American foster parents in San Francisco so that out-of-county placement will not be necessary. If recruitment succeeds, out-of-county placements should not be necessary.

DSS also administers GAIN (Greater Avenues for Independence). Under this program, AFDC clients are provided counseling, testing, and child care assistance to enable them to enter job placement or educational and vocational training programs. The program is fully funded by the State; its goal is to provide AFDC clients the support they need to become self-sufficient. The African-American community has proposed an innovative use of GAIN: to identify participants who may be interested in foster parenting and to direct these participants to preparatory medical training which would qualify them for training as foster parents for medically fragile infants.

The number of medically fragile infants in the African-American community is growing at an alarming rate. This innovative use of GAIN would keep these children in the African-American community and provide them the special care they need. The Task Force endorses this proposal and recommends that DSS institute this program as soon as possible. The program would also provide these GAIN participants with the training and skills necessary for other medically-related jobs.

IV. Fraud Early Detection and Prevention Program (FRED)

In July 1989, the Department of Social Services (DSS) began to develop a Fraud Early Detection and Prevention Program (FRED) in order to detect and prevent fraud in programs administered by DSS. The program is State funded; participation by San Francisco in the program is voluntary. The program became operational on February 20, 1990.

DSS states that the goal of the program is to develop an early detection and prevention program reduce and/or eliminate the need to collect reimbursements from recipients who have defrauded the programs, as well as to reduce the number of welfare fraud referrals and prosecutions. FRED was designed to achieve this goal through the verification of information presented in client applications. The verification was to be accomplished through unannounced home visits and other investigative activities conducted by eligibility workers.

FRED received 101 referrals in March 1990, its first full month of operation. The cases to be reviewed by FRED are referred on the basis of written criteria. Of these 101 referrals, 58 clients did not have their eligibility affected, 37 clients were denied or discontinued assistance, and 6 clients withdrew their applications.

The Task Force has found several aspects of the FRED program to be disturbing. First, the initiation of the FRED program was not announced to DSS clients. As a result, many clients were frightened by the program when it began. DSS has promised to distribute a brochure explaining the program, but DSS should have done so before the program became operational. DSS must perform meaningful and culturally sensitive community outreach and education about this program as soon as possible.

Under DSS's original policy, FRED workers were to make unannounced home visits to clients, and they did so during FRED's first month of operation. The Task Force believes that such visits are intrusive, traumatic, and not respectful of clients' privacy. Some clients do not understand who the FRED workers are; they think that the FRED workers are immigration workers or officials who will turn information over to the Immigration and Naturalization Service. The Task Force is pleased that the Social Services Commission has recently decided to eliminate these unannounced visits. The visits are not required by the State funding protocols and scheduled appointments should provide the FRED workers with the same information they would have obtained from the unannounced visits.

Collateral contacts, i.e., contacts of such persons as landlords and other persons, are used as part of the verification process. FRED workers claim that they will not make collateral contact with anyone unless the client has provided written authorization. The Task Force believes that many clients will feel pressured into allowing these collateral contacts. The Task Force recommends that the

use of such contacts be minimized to instances in which the client has not provided the necessary verification information.

In several instances during the program's first month of operation, clients who were eligible for assistance have been unable to obtain aid as quickly as required because FRED program activities have delayed the issuance of such aid. These delays are contrary to the guidelines established for the FRED program and should be eliminated. DDS should monitor the program to ensure that the guidelines are being followed. Delays in aid to which a person and family are entitled are unacceptable.

The Task Force recommends that the Department of Social Services and the Social Service Commission seriously reconsider the FRED program. By working with the affected communities, DDS may be able to establish an improved verification program through improving normal eligibility screening techniques and quality control. Such a collaborative approach may achieve FRED's goals without the current problems.

V. Visitation in Intensive Care Units or Other Restricted Units in City Health Facilities.

Visitation of patients in intensive care units or other restricted units in City health facilities is limited to the **immediate** family. However, the Department of Public Health has informed the Task Force that it takes a **dynamic** view of the meaning of the term **immediate** and accords visiting rights to those persons closest to the patient, especially encouraging all visitors desired by the patient. However, this policy appears to have been developed ad hoc, and the Department of Public Health has no written policy on what it considers to be a family. Problems can arise if the patient is comatose or otherwise unable to adequately express his/her wishes as to who should be permitted to visit. In such a case, like that of Sharon Kowalski and her domestic partner, Karen Thompson, the domestic partner may be denied visitation rights by other family members. In Sharon Kowalski's case Karen Thompson fought for five years for rights which should have been recognized without question by Ms. Kowalski's health care providers. The Task Force thus recommends that the Health Commission adopt a written policy which utilizes the Task Force's description of family in order to avoid potential situations when the ad hoc policy is challenged. Moreover, the Task Force also encourages unmarried individuals and those in domestic partner relationships to take precautionary measures in advance of a medical emergency, especially by executing durable powers of attorney for health care (DPA), which is permitted by California law. A power of attorney is a document given by one person to another authorizing the latter to act for the former in certain circumstances, such as making medical decisions.

The Task Force is encouraged that the Health Commission has passed a resolution directing the Director of Public Health to encourage and facilitate the adoption of broad visitation policies by private San Francisco hospitals. The policies should recognize significant relationships not based on blood or marriage, and should accord persons who are in such relationships with patients the same visitation rights as other family members. These policies should be clearly stated in writing.

VI. Family Related Services of the Department of Public Health

The Department of Public Health provides family-related services in three situations: 1) when the Department needs to have a family take over a person's continuing medical care, e.g., outpatients at General Hospital; 2) when the Department needs to work with a family to address one family member's problems; 3) when support services are needed by family members who are caring for other family members. The Task Force found that as with visitation rights, the Department takes a **dynamic** view of family and works with whatever family unit presents itself. The Task Force applauds this sensible approach; a restrictive family policy would not assist the Department in effectuating these programs. However, as with visitation rights, the Task Force believes that a written policy statement as to the definition of family would allow the Department flexibility, and at the same time would avoid potential problems.

VII. In-Home Supportive Services

The In-Home Supportive Services (IHSS) program provides assistance to eligible aged, blind, and disabled persons who are unable to remain safely in their own homes without assistance. The primary services available through the IHSS program are domestic and related services; nonmedical personal services, such as bathing and dressing; essential transportation; protective supervision, such as observing the recipient's behavior to safeguard against injury; and paramedical services, which are performed under the direction of a licensed health care professional and are necessary to maintain the recipient's health.

The IHSS program, while State financed, is administered locally by the Department of Social Services (DSS) under broad guidelines that are established by the State government. Services are delivered by individual providers hired by the recipients or by private agencies under contract with the City and County of San Francisco. Family members can qualify to be individual care givers, providing compassionate care to their loved ones and helping to ease the financial burden which has fallen upon the family for providing such care.

The Governor's 1990-91 budget proposal would eliminate payments to relatives who provide IHSS services to family members with certain functional levels. DSS estimates that this proposal would prevent San Francisco from paying several hundred relatives who currently provide IHSS services to their families. The Task Force recommends that the City's lobbyist work to oppose this budget cut. If this budget cut is implemented, many elderly persons would be denied care by loving and concerned family members. Such care can improve the well-being of the elderly and maintain family ties.

VIII. Coroner's Office

The Coroner's Office is responsible for determining the cause of a person's death and making arrangements for the disposition of the body. However, the jurisdiction of the Office is limited to cases in which someone dies of unknown causes and there is a suspicion of foul play; someone dies at home who is not under the care of a physician; someone dies with no known relatives to claim the body; or other situations in which there are unusual circumstances surrounding a death.

The Task Force is concerned about the Office's determination of who has the right to a deceased person's body. Once a person dies and the body is in the possession of the Coroner's Office, the body will be released only to a surviving spouse or blood relative of the deceased. The definition of relative is based on a blood relationship, and is controlled by California state law.⁷¹ As a result, a surviving domestic partner has no right to his/her deceased domestic partner's body under this definition.

The Task Force notes that this problem can be overcome by the use of a durable power of attorney for health care (DPA). Unlike a regular power of attorney, a DPA survives the disability, incapacity or death of the principal. Thus, a DPA can be effectively used by a person to direct the desired disposition of his/her remains.⁷²

The designations in durable powers of attorney have been upheld by the courts. In cases in which disputes have arisen, the Coroner's Office also tries to have the parties work out the situation, an approach which has proven to be successful. However, the Task Force believes that a broader definition of family, i.e., one which recognizes a domestic partner relationship, is necessary under California law to eliminate problems in this area. The Task Force recommends that the City's lobbyist should work to have the definition changed.

IX. Family Violence

Domestic violence in San Francisco is a serious problem which cuts across socio-economic groups and threatens San Francisco's families. Family and relationship motivated murders account for the largest category of homicides in the City. Moreover, 41 percent of all assaults and weapon-related calls received by the San Francisco Police Department are family-violence related.

The San Francisco Family Violence Project was founded in March 1980. From its inception, the Project adopted a multilevel approach to the crime of domestic violence and its effect on victims, on their families, and on society in general. Programs developed and implemented by the Project have included comprehensive services to victims of domestic violence and their families, extensive public education and prevention campaigns about domestic violence, and the introduction of new procedures to improve the criminal justice system's and medical system's response to domestic violence.

Police Department policy now treats violence in the home as a crime which is not appropriate for dispute mediation. Additionally, victim services, such as shelter and counseling, have been increased, and assistant district attorneys with special experience and training in prosecuting domestic violence have been assigned to take these cases. While the Task Force strongly approves of these measures, it is concerned that sufficient resources are not being directed to the women and children who are the victims and/or witnesses of family violence. Additional shelters are needed, as are legal assistance programs to speed cases through the civil or criminal justice systems. Counseling and support therapy are particularly needed for children. These children can become psychologically scarred and are in need of treatment to prevent them from developing psychological problems or from turning to violence themselves. The Task Force thus urges that these additional shelters and legal assistance programs be provided.

THE CITY OF SAN FRANCISCO AS A CONTRACTOR OF SERVICES

The Task Force believes that its recommendations on family policy should also be adopted by the private sector. Private institutions and businesses should realize that employment policies which take a broad and realistic view of how families exist today, and which recognize the interrelationship between family and work, are in society's and business's best interests. The Task Force does not, however, recommend that the City pass legislation requiring private employers to adopt the same family policies as the City's. However, when the City pays private businesses to provide services to its families, the City should require that such businesses use the City's description of family to specify who is eligible for, or covered by, the services which the City has purchased. As examples, the Task Force has identified two such programs in which private companies provide services to City residents.

I. Discrimination Against Families in Homeless Shelters

The City, through the Department of Social Services (DSS), contracts with different entities, such as Traveler's Aid, to provide shelter to homeless persons. Such shelters are either sex segregated or are for families only. The contracts, as currently written, define family by blood relationship or marriage. Thus, it is possible that homeless shelters may not accept a gay male or lesbian couple with children as a family unit. The Task Force notes that such a problem has not yet arisen and that DSS, in response to the work of the Task Force, has revised its definition of family to include domestic partners.⁷³ However, because this revision has not yet been approved by the Social Services Commission, the Task Force recommends that the Commission immediately adopt the Task Force's more inclusive description of family. Further, all homeless shelters should be notified of the revision and instructed to accept lesbian and gay male families.

II. Nutrition Programs for the Elderly

The Commission on Aging contracts for nutrition programs for the elderly. Most of the provisions of this program are governed by the federal Older Americans Act and regulations promulgated by the U.S. Department of Health and Human Services (HHS). The program provides meals for senior citizens at a voluntary donation rate. The spouse of a senior may also receive meals at the same rate, regardless of age. However, anyone under the age of 60 who is not a spouse must pay a rate which is higher than the senior rate.

Many senior citizens are widows or widowers. Because of Social Security regulations heterosexual senior citizens will face a reduction in benefits if they marry again and therefore may choose to live in a domestic partner relationship. Other senior citizens are gay males or lesbians, and may also have domestic partners. Because these relationships are not legally recognized, the domestic

partners of heterosexual, gay male and lesbian seniors are discriminated against in these nutrition programs if they are under age 60. Such partners are forced to pay a rate to receive services which is higher than that paid by a spouse of any age. The Task Force recommends that the City lobby HHS to revise the regulations pertaining to this program in order to eliminate this discrimination.

OTHER FAMILY ISSUES AND RECOMMENDATIONS

I. Housing Issues

San Francisco suffers a serious lack of affordable housing for its families, particularly minority families. The reasons underlying the lack of affordable housing for San Francisco's families are as complex as the issue is important.⁷⁴ The potential solutions to the problem involve all levels of government and include rent control, vacancy control and the construction and rehabilitation of affordable housing.

The Task Force believes that affordable housing is essential if a family is to remain united, and to provide the nurturing and support its members need. It is difficult for the Task Force, with its limited resources, to address the issue of affordable housing in its entirety or in great detail. However, the Task Force is particularly concerned with the risk of losing subsidized housing such as that provided by the Section 8 Housing Assistance Payments (HAP) Program.

The Section 8 program is the primary federal subsidy program presently available to assist in the production of new housing for low and moderate income persons and families. The program is administered by the U.S. Department of Housing and Urban Development (HUD). One part of the Section 8 program provides for monthly payments to apartment complex owners on behalf of qualified tenants who are occupying units which the owners and HUD agree to designate as Section 8 dwelling units. These may be all of the units in the apartment complex or less than all of the units. Payments to the apartment complex owner are made pursuant to the terms of a HAP contract for periods generally not exceeding twenty years (or as long as thirty years in the case of certain apartment complexes financed through state and local financing programs).

Tenants pay rent to the apartment complex owner, plus a HUD-approved allowance for utilities if utilities are separately charged to the tenants, that together equal 30% of the tenant family's annual income. HUD has established a "contract rent" amount for each unit in the apartment complex; this amount is the total rent that the complex owner is to receive for that unit. That part of the "contract rent" that is not covered by the tenant's rent obligation is paid to the apartment complex owner by HUD under the HAP contract.

Under another part of the Section 8 program, tenants choose, with some limitations, the rental unit they will occupy from the private rental market and use either certificates or vouchers from HUD to help defray part of the rental cost. As in the other part of the Section 8 program, the tenant pays only 30% of his/her adjusted income in rent.

The problem which will adversely affect low income families in San Francisco and the entire nation is that the Section 8 subsidy contracts on many housing units will soon be ending and will not be renewed. It will then be the full responsibility of the tenants in the formerly subsidized units to pay the market rate rents. Low income families will inevitably be unable to meet these payments and many will be forced to leave their homes. These evictions will increase the stresses already felt by these families, will lead to family displacement and will increase the problem of homelessness. It is estimated that the subsidy status of 1.8 million apartments in the entire nation is endangered.⁷⁵ In San Francisco the subsidy contracts on 5525 housing units will expire by the year 2000.⁷⁶

Under a second type of subsidized housing program, Federal mortgage subsidies have been provided to private developers who, in turn, have agreed to lease some or all of their units to low and moderate income tenants for at least 20 years. Under these programs, building owners generally receive mortgages with only one to three percent interest over 40 years. However, after 20 years owners are permitted to leave the subsidy program by paying off their mortgages in full. Once the owners prepay their mortgages, they are no longer required to reserve low cost rental units for low and moderate income tenants. Instead, the owners are free to charge whatever rents the market will bear. Without "use restrictions" (i.e., the restriction that units be reserved for those with low and moderate incomes), owners may also choose to convert their buildings into condominiums or other commercial uses. Low income tenants could be forced to pay substantially higher rents or to find other housing.⁷⁷

While these housing programs are Federal programs, it is in the best interest of the City and its families to ensure that subsidized housing is not lost. Thus, the Task Force recommends that the issue of subsidized housing be addressed quickly; Congresswoman Nancy Pelosi has already held hearings on this issue. The Task Force recommends that the City work closely with HUD to address this problem. An innovative program, involving transfer of contracts to new low-income housing, is already being tried in Indianapolis.⁷⁸

The Task Force further supports Supervisor Ward's proposed San Francisco Assisted Housing Preservation Ordinance. The ordinance would require that tenants be given advance notice if the owners of their complex are planning to prepay their mortgage or to opt out of their Section 8 contract, or if the Section 8 subsidy is expiring. The ordinance would further provide tenants, nonprofit organizations and City agencies with the first right to purchase a building if an owner tries to sell a development and if the sale would result in the conversion of the development from its current low/moderate income use. Families which are already facing great economic stress should not, in the Task Force's opinion, be subjected to even greater economic pressures due to the end of subsidized housing and the City should do all that it can to preserve such housing.

II. Property Tax Reassessment

If a property is acquired by two persons in joint ownership, but thereafter one of the joint owners acquires the other owner's share, such as upon the death of the other owner, California state law mandates that when single ownership commences the newly acquired part be reassessed by the City at its current value. Exceptions to this reassessment rule are provided for interspousal transfers and for any transfers between parents and children. Domestic partners are not excepted from this reassessment rule. Thus, in a domestic partner family one partner may be faced with a great financial burden following a transfer from the other domestic partner. This may be especially true if the domestic partners are elderly and one partner inherits the other partner's share. The Task Force recommends that the City lobby on the state level for the addition of transfers between domestic partners as an exception to the reassessment rule.

III. Family Registry

The Task Force recommends that the City create a system for making an official record of extended and alternative families (distinguishing those in which children are members) and a separate system for making an official record of committed couples.

A. Why Have a System for Recognizing Families and Couples?

First, registry systems like these would make it easier to administer the various policies which this report recommends that the City adopt. It is possible to have the City adopt policies which recognize family diversity on a department-by-department basis, and the City should do so. But a central system for recognizing extended and alternative families would make such policies far easier to administer. For example, family care leave should cover not just the care of an employee's spouse and children, but any person who is a part of the employee's family. A central registry would allow the employee to verify that the person for whom the employee seeks to provide care is a part of the employee's recognized family unit. There are a number of ways to make such a policy work, but for alternative and extended families, a central system would make implementation easier and more uniform.

Second, private businesses and other institutions are more likely to follow the City's lead in recognizing alternative and extended families if the City has already described what it means by alternative/extended families and has established a system for recognizing them. A City-created system would make it easy for private institutions to use the same description of alternative/extended families, so that recognition of family does not become an inequitable patchwork.

The Task Force recommends that a separate system for recognizing the relationships of committed couples be created. We do so because the relationship of two adults who have committed themselves to each other is fundamentally different from other relationships. There may also be some circumstances in which institutions legitimately may wish to take special account of a person's primary relationship with one other person.

In particular, lesbian and gay male couples have been subjected to so much social disapproval and institutional discrimination that the Task Force fears that they will not be fully recognized as members of families simply through changes in various policies. Since society has often not included the relationships of lesbians and gay men in the term family, lesbians and gay men often assume that they are not meant to be included in family policies. Unless the City takes affirmative steps to recognize the legitimacy of lesbian and gay male relationships, lesbians and gay men may continue to assume they are not included.

The policy changes which this report recommends are intended not simply to alter City practices here and there, but to encourage an attitude which promotes families throughout the entire City government. Just as lesbians and gay men sometimes assume that when the term family is used, they are not included, other communities in the City may in fact exclude them and their families unless the City makes it very clear that in San Francisco the term family includes lesbians and gay men. Individual policy changes will not do that. A system which recognizes lesbian and gay male relationships may help to start the process.

B. A Few Comments on Details

While the Task Force will leave the details of the proposed registry systems to the Board of Supervisors and the Mayor, the Task Force believes that a few comments on the subject are appropriate.

It is a central proposition of this report that the City should recognize as a family any group of people who share each other's lives in a committed relationship of mutual caring and love. Any system set up to acknowledge and record families should be equally broad.

A family (including a family which is a committed couple) should not be required to register in order to be covered by City policies which affect families. But all families, particularly alternative and extended families, ought to be able to use the registry system, and should be encouraged to do so.

Since committed couples can be (and frequently are) parts of alternative and extended families, they should be able to be included as part of such families recognized in the system.

Any system ought to recognize the relationships between adults and any children for whom they are responsible. Such recognition would be especially helpful in administering the many programs and policies directed at helping families with children.

Finally, the guiding principle of this report ought to be the guiding principle for the design of the systems: that the City ought to do whatever it can to encourage the formation and preservation of all types of families.

IV. Monitoring and Implementation of Recommendations

The Task Force is particularly concerned that its recommendations be implemented effectively, and that adequate provisions be made for overseeing of the implementation process. To accomplish these goals, the Task Force recommends the creation of a Commission on Children, Youth and Families to monitor, report on, and lobby for the implementation of the Task Force's recommendations. The creation of such a commission would also provide concrete evidence of San Francisco's commitment to its families. The Commission would provide a centralized independent agency to address family-related issues. The existence of such an agency would facilitate coordination of family-related services provided by different City agencies and/or departments, such as the Department of Social Services, the Department of Public Health, the Department of Parks and Recreation, and the police. It would also permit coordination between such City agencies and/or departments and the private sector. Such coordination would result in more efficient use of the City's resources which are directed towards children and families. The Commission, which would be created either by an ordinance passed by the Board of Supervisors or a Charter amendment, would replace the Mayor's Office of Children, Youth and Families.

Pending the creation of the Commission, the Task Force recommends that a subgroup of this Task Force be designated by the Mayor as a Monitoring/Implementation Committee, after consultation with the Task Force's Chair. This committee would monitor the City's progress towards implementing the Task Force's recommendations, reporting at six month intervals to the Mayor.

V. Lobbying Efforts

Working alone, the City and County cannot achieve the goals outlined in this report. Legislation which addresses family issues and which affects San Francisco's families will be introduced in the State Assembly and in Congress and should be vigorously supported by the City. Moreover, the Task Force recommends that the City's lobbyist review proposed state legislation and determine if it is friendly to the families of San Francisco and as inclusive as possible. Efforts should be directed to support such legislation and oppose or modify other legislation which does not meet the goals of this report.

ENDNOTES

1. These departments, agencies and commissions included the Civil Service Commission, the Health Commission, the Department of Public Health, the Department of Social Services, the Recreation and Park Department, the Rent Control Board, the Coroner's Office, the Public Utilities Commission, the Mayor's Office of Housing, the Mayor's Office of Children, Youth and Family, the Mayor's Office of Community Development, the Commission on Aging, the Family Violence Project, the Health Service Board, the Retirement Commission, the Sheriff's Office, and the Assessor. The Task Force would particularly like to thank the staff of the Department of Social Services for their assistance and cooperation.
2. See Appendix A.
3. For a complete list of those persons who testified, see Appendix B.
4. Johnston, W. and Packer, A., Workforce 2000 (Indianapolis: The Hudson Institute, 1987), p. 85.
5. The Research Institute of America, Inc., Research Institute Recommendations, Volume 36, No. 51, December 19, 1986.
6. U.S. Department of Commerce, Bureau of the Census, Current Population Reports, Series P-20, No. 410, "Marital Status and Living Arrangements: March 1985."
7. The New York Times, March 18, 1990.
8. The population of the City and County of San Francisco in 1985 was estimated to be 751,405. The composition was 373,205 (49.7%) White; 89,100 (11.85%) African-American; 91,505 (12.1%) Latino; and 197,600 (26.3%) Asian, Pacific Islander and Native American. (U.S. Bureau of Census, Population Estimates by Race and Hispanic Origin for States, Metropolitan Areas and Selected Counties, 1980-1985). The corresponding distribution for the United States as a whole in 1980 was 80 percent White; 12.3 percent African-American; 6.4 percent Latino; 2.2 percent Native American and Asian and Pacific Islander. (U.S. Department of Labor, Employment Training Administration, Social Indicators for Planning and Evaluation - San Francisco County, California, April 1982).
9. San Francisco Chronicle, June 21, 1989.
10. The Department of Public Health's Office of Lesbian/Gay Health Services in its December 1989 report estimated that San Francisco's sexual minority communities comprised 15-20% of the City's population.

11. U. S. Department of Labor, Social Indicators for Planning and Evaluation, supra.
12. Time Magazine, April 9, 1990.
13. U.S. Department of Labor, Social Indicators for Planning and Evaluation, supra.
14. Ibid.
15. Marin, B. "Drug Abuse Treatment for Hispanics: A Culturally Appropriate, Community-oriented Approach," In Watson, Prevention and Treatment of Drug and Alcohol Abuse, Humana Press.
16. Newsweek, March 12, 1990.
17. San Francisco Examiner, June 12, 1989.
18. See, e.g., Gay Rights Coalition of Georgetown University Law Center v. Georgetown University, 536 A.2d 1 (D.C. 1987).
19. Task Force on Family Diversity, City of Los Angeles, Final Report, p.22.
20. Testimony by Dr. Catherine L. Gillis, Associate Professor, Department of Family Health, School of Nursing, University of California, March 29, 1990.
21. The Bureau of Labor Statistics predicts that the growth of the U. S. labor force will slow between 1988 and 2000. The growth rate between 1976 and 1988 was 2% per year. From 1988 until 2000 the labor force is predicted to grow only 1.2% per year.
22. Between now and the year 2000, the number of workers between the ages of 35 and 54 will increase by more than 25 million, and the median age for employed Americans will rise to 39 years, up from 36 in 1987 (Johnston, p. 81).
23. Sixty percent of all women over age 16 will be at work in the year 2000 (Johnston, supra).
24. Over the next several years, almost a third of all new entrants into the labor force will be minorities (Johnston, pp. xx, 89).
25. Between 1970 and 1980, the foreign-born population of the United States increased by about 4.5 million, and approximately 450,000 more immigrants are expected to enter the United States yearly through the end of the century. Immigration at this rate would add about 9.5 million people to the U.S. population and four million people to the labor force. If illegal immigration also continues at recent rates - about 750,000 per year - total immigration would add 16.1 million to

the population and 6.8 million to the labor force. (Hopkins, K. and Johnston, W., Opportunity 2000, Indianapolis: The Hudson Institute, 1988; p. 10).

26. U.S. Department of Labor, Employers and Child Care: Benefiting Work and Family, 1989, p.7.

27. Ibid.

28. Hughes, D., and Galinsky, E., Balancing Work and Family Life: Research and Corporate Application (Bank Street College: 1988).

29. Galinsky, E., Family Life and Corporate Policies, 1986.

30. Report of the Commission on Workforce Quality and Labor Market Efficiency, Investing in People, p. 25

31. See Friedman, D., and Gray, W., A Life Cycle Approach to Family Benefits and Policies, The Conference Board.

32. For example, several department stores in the Washington, D.C. area have extended discount privileges to the domestic partners of their employees (The Washington Blade, March 9, 1990).

33. Poll taken by the Gallup Organization for the Employee Benefit Research Institute, Washington, D.C.

34. The Wall Street Journal, May 4, 1990.

35. United States General Accounting Office, Parental Leave - Revised Cost Estimate Reflecting the Impact of Spousal Leave (Washington, D.C.: 1989).

36. The Task Force defines "dependent child" as a child for whom the employee has parenting responsibilities and who lives in the same house as the employee.

37. Charter Sections 3.680 - 3.682 and 8.420 - 8.432.

38. Charter 8.423.

39. Testimony of Randy Smith, Executive Director of the Health Service Board of the City and County of San Francisco, March 29, 1990.

40. The survey form is reproduced in Appendix C. The survey methodology is described in more detail in Section 3, "Health care benefits for domestic partners," below.

41. The children are ineligible for coverage because they exceed the age limits for enrolment.

42. This would be an appropriate task for the Office of Employee Benefits, whose creation the Task Force recommends.
43. The survey form is reproduced in Appendix C.
44. As of July 1, 1989, there were 31,018 active City employees eligible for insurance offered through the Health Service Board.
45. However, a domestic partner who is covered at the time the employee retires will continue to be eligible for coverage.
46. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), provides employees and certain dependents with the right to continue healthcare coverage for 18 or 36 months in the event of termination of employment, dissolution of marriage, or other specified occurrences. Domestic partners will not have any continuation rights under COBRA. Two of the HMOs objected to the voluntary extension of COBRA rights to domestic partners at this time. The Task Force views the extension of COBRA rights to domestic partners on the same basis as provided to spouses to be an important issue of basic equity, and recommends that the issue be reviewed after domestic partner coverage has been in effect for one year.
47. As of July 1, 1989, 3,205 active employees were enrolled in Bridgeway and 3,462 in Bay Pacific, for a total of 6,667 employees. The expected number of new AIDS cases per year among their domestic partners is thus
$$6,667 \times .019 \times .5 \times .06 = 3.8.$$
48. Charter Section 3.671.
49. In some cases 75% of the pension continues.
50. In some cases, a spouse who was married to the employee for one year at the time of death is eligible; in other cases, the spouse is also required to have been married to the employee at the date of retirement.
51. Charter Section 3.592.
52. This group includes the following classifications: Transit Operator (9163), Transit Supervisor (9139), Transit Manager (9141 and 9155), Claims Investigator (9155), Senior Claims Investigator (9156), Claims Adjustor (9157), Assistant Claims Agent (9158), General Claims Agent (9159).
53. In a job sharing arrangement, two persons share the responsibilities of one full-time job. With job sharing, the two sharers can restructure a career-oriented professional position that cannot be easily separated into two part time jobs. The employer has more flexibility because both employees can work during peak work hours. Sharers have more flexibility in their schedule and provide more continuity

at work because one can cover for the other's illnesses or child care emergencies. Job sharing offers an excellent opportunity for employers to retain valued employees after childbirth and for employees to continue their careers at a reduced work schedule. See, Scordato, C. and Harris, J., "Workplace Flexibility," HR Magazine, January, 1990.

54. Flexplace work or telecommuting is a broad term for employees working at alternate sites either at home or in a satellite office. The employee thus has more control over his or her work schedule and eliminates commuting. Parents may prefer the flexibility of work at home when they have many parenting responsibilities. The Congressional Office of Technology Assessment estimates that 15 million computer jobs could be relocated to homes. However, a major concern of employee representatives is that homeworkers may be exploited by the employer. U.S. Department of Labor, Employers and Child Care, supra, p.29, Scordato and Harris, supra.

55. A part-time program, known as V-Time (voluntary reduced work time) was developed by the Service Employees International Union (SEIU) in Santa Clara, California. Under a V-Time plan, an employee can reduce his/her time worked by a certain percentage for a limited time period. The employee retains seniority status and full benefits. Under other part-time plans the workers receive a pro-rata share of benefits.

56. The New York Times, March 10, 1990.

57. Galinsky, E. and Hughes, D., Paper presented at the Annual Convention of the American Psychological Association, New York, N.Y. (August 1987).

58. Ransom, C., Ashbacher, P., and Burud, S., "The Return in Child-Care Investment," Personnel Administrator, October, 1989.

59. Testimony of Lynn Beeson, March 29, 1990.

60. U.S. Department of Labor, Employers and Child Care, supra, p.20.

61. Ibid.

62. Friedman, D., Issues for an Aging America - Elder Care, The Conference Board.

63. A survey by the New York Business Group on Health of member organizations found that 60% saw evidence of excessive stress and physical complaints among employees with elder care responsibilities. Half reported decreased productivity or work performance.

64. Testimony of Lynn Beeson, March 29, 1990.

65. An intergenerational day care center was recently started by the Stride Rite Corporation. The program will provide 10 hours of care for 55 youngsters and 24 elders who need assistance. The Wall Street Journal, February 20, 1990.
66. Kirrane, D., "EAPs - Dawning of a New Age," HR Magazine, January 1990.
67. A domestic partner is not considered to be a "relative" of the child. This term applies only to blood relationships. DSS overcomes this problem by licensing domestic partners as foster parents. However, the Task Force recommends that the term "relative" be changed to comport with the expanded definition of "family" which we have adopted. Such a change must occur on the Federal level; the city should lobby for a change.
68. Testimony of Dr. Julianne Malveaux, March 29, 1990.
69. Testimony of Ann O'Reilly, March 29, 1990.
70. The San Francisco Chronicle, April 13, 1990.
71. Health and Safety Code Section 7100.
72. Ray, S.A., "Durable Power of Attorney (DPA)," AIDSLaw (San Francisco: AIDS Legal Referral Panel, 1988).
73. Testimony of Ann O'Reilly, March 29, 1990.
74. See, Lazere, E. A Place to Call Home - The Crisis in Housing for the Poor, The Center on Budget and Policy Priorities (Washington, D.C., April 1990).
75. The New York Times, April 15, 1990.
76. California Coalition for Rural Housing Project, Inventory of Low Income Rental Units Subject to Termination of Federal Mortgage and/or Rent Subsidies, 1988-2008.
77. Lazere, supra, p. 37.
78. The New York Times, April 15, 1990.

APPENDICES

APPENDIX A
PERSONS CONTACTED DURING THE INCLUSION PROCESS

1. Harry Britt
President, Board of Supervisors
2. Rev. Amos Brown
Third Baptist Church
3. Gordon Chin
Director, Chinese Community Housing Corporation;
4. Anni Chung
Director, Self Help for the Elderly
5. James G. Fussell, Jr.
Executive Director, San Francisco Planning and Urban
Research Association
6. Anita Friedman
Jewish Family Services
7. Ed and Peg Gleason
The Archdiocese of San Francisco
8. Jim Gonzalez
Supervisor
9. Shirley Gross
Bay View-Hunters Point Foundation
10. Terrence Hallinan
Supervisor
11. Ricardo Hernandez
Public Guardian
12. Richard Hongisto
Supervisor
13. Tom Hsei
Supervisor
14. Willie Kennedy
Supervisor

15. James Lazarus
Vice President for Public Affairs
San Francisco Chamber of Commerce
16. Bill Maher
Supervisor
17. Dr. Julianne Malveaux
18. Lulann McGriff
Regional President
National Association for the Advancement of Colored People
19. Mel Miles
Executive Director
Parent Infant Neighborhood Center
20. Political Action Committee
Harvey Milk Lesbian and Gay Democratic Club
21. Concha Saucedo
Instituto Familiar de La Reza
22. Kent Sims
Economic Development Council
23. Sharon Trescunoff
Legislative Aide to Supervisor Willie B. Kennedy
24. Vu-Duc Vuong
Center for Southeast Asian Refugee Resettlement
25. Po Wong
Executive Director
Chinese Newcomers Service Center

APPENDIX B

WITNESS LIST - PUBLIC HEARING - MARCH 29, 1990

1. Mr. Bill Marquis
President, San Francisco Senators
2. Ms. Kate Favetti
Civil Service Commission
3. Mr. Walter Johnson
Secretary-Treasurer
San Francisco Labor Council
4. Mr. Robert Edmonson
Chief Executive Officer
Bridgeway Plan for Health
5. Mr. George Wesolek
The Archdiocese of San Francisco
Executive Director, Justice and Peace Commission
6. Honorable Art Agnos
Mayor, City of San Francisco
7. Mr. Paul Varacalli
Executive Director
United Public Employees Local 790
Service Employees International Union
8. Ms. Renee Kulleck
Kaiser Permanente Health Plan
9. Ms. Ann O'Reilly
Assistant General Manager
Family and Children's Services
Department of Social Services
10. Mr. Ray Antonio
Transport Workers Union, Local 250-A

11. Dr. Steve Morin
Health Assistant to Cong. Pelosi
12. Ms. Magdalena Jacobsen
Office of the Mayor
Director, Employee Relations Division
13. Mr. Keiran Murphy
Retirement Commission
14. Mr. Randy Smith
Executive Director
Health Service Board
15. Mr. Keith Choy
Office of the Mayor
Director, Office of Children, Youth and Families
16. Dr. Catherine Gillis
University of California at San Francisco
17. Rev. James Page
President, Association of Hispanic Evangelical Ministries
18. Ms. Lynn Beeson
Office of the Mayor
Director, Office of Child Care
19. Mr. David Smith
Pastor, His Way Fellowship
20. Mr. Todd Hill
Harvey Milk Gay and Lesbian Democratic Club
21. Mr. Jim Robinson
His Way Fellowship
22. Rev. W. Holt
23. Ms. Rosario Navarette
Commission on the Status of Women
24. Mr. Raymond Kinoy
25. Mr. Jack Bellingham

26. Mr. David Innes
Hamilton Square Baptist Church
27. Rev. Charles McIlhenny
First Orthodox Presbyterian Church
28. Ms. Gretchen Meinke
San Francisco Adult Day Health Network
29. Mr. Mike Moxley
30. Ms. Nina Kaiser
Buena Vista Lesbian and Gay Parents
31. Dr. Thomas P. Mammen
Chairman, Federation of Indo-American Associations
32. Mr. Steve Ashton
Calvary Baptist Church
33. Mr. Larry Brinkin
34. Mr. W. Simon Tse
San Francisco Chinese Alliance Church
35. Ms. Catherine Daly
American Civil Liberties Union
36. Dr. Richard Cantrell
Hamilton Square Baptist Church
37. Ms. Jacquie Hale
38. Rev. Tim Dupre
Director, Booker T. Washington Community Center
39. Dr. Julianne Malveaux
40. Ms. Gwenn Craig
Commissioner, Police Commission
41. Mr. Trent Orr
Commissioner, Recreation and Parks Department
42. Ms. Cathy Mibach
Council of Catholic Women

43. Mr. Barry Borrowman

Office of the Mayor
SAN FRANCISCO



ART AGNOS

January 24, 1990

Dear City Employee:

Mayor Agnos has appointed a Task Force on Family Policy to examine how city policies affect families. The Task Force is considering a wide range of issues, ranging from the special needs of families in which children are cared for by a grandparent to the provision of benefits to the extended families of city workers.

As part of its work, the Task Force is studying the feasibility of providing health insurance benefits to extended families of city employees. Extended family members might include the parents, adult children, brothers and sisters, or nonmarital partners of city employees. Extended family members currently can benefit from the city's pension and life insurance programs, but not from the city's health insurance. This possible extension of health insurance benefits is not related to Proposition S on last November's ballot, which provided for registration of "domestic partners."

The enclosed survey is being sent to a random sample of city employees to assist the Task Force in determining the number of extended family members that might be covered for health insurance. Because you have been chosen as part of a random sample, you will be speaking for as many as 30 other city employees. Whether or not you have extended family members who might benefit from health insurance, it is important that you complete and return the survey. Your cooperation is extremely important in helping us to estimate how many employees would use extended family benefits.

Please take the time to fill out the attached questionnaire and return it in the enclosed envelope by February 10, 1990. The return envelope contains no markings by which we could identify you, so your response will be completely anonymous. If you have any questions about this survey, please call Ed Lee in the Mayor's Office of Employee Relations at 554-8723.

Sincerely,

A handwritten signature in black ink, reading "Roberta Achtenberg".

Roberta Achtenberg, Chair
Mayor's Task Force on Family Policy

Mayor's Task Force on Family Policy

Family Health Benefits Questionnaire

Instructions for Returning Questionnaire: Place the completed questionnaire in the enclosed stamped envelope, and drop it in any mail box. The envelope contains no markings by which we may identify you, so that **your response is completely anonymous.**

1. What is your age? ______{1,2} sex? (please circle one) Male₃ Female₄
What is the Zip Code of your Residence? ______{4,5}
2. What health insurance coverage do you have currently? (please check all that apply)
_____₁ Coverage under your city employee health insurance
_____₂ Coverage obtained through your spouse's employer
_____₃ Other health insurance coverage (please indicate whether
_____₄ group or
_____₅ individual coverage)
_____₆ No health insurance
3. Are you legally married? (circle one) YES₁ NO₂.
If you answered NO, please go to question 5.

IF YOU ARE LEGALLY MARRIED, PLEASE ANSWER QUESTION 4.

4. If you answered YES to question 3, what health insurance coverage does your spouse (husband or wife) have currently? (please check all that apply)
_____₁ Coverage under your city employee health insurance
_____₂ Coverage obtained through your spouse's employer
_____₃ Other health insurance coverage (please indicate whether
_____₄ group or
_____₅ individual coverage)
_____₆ No health insurance

What is your spouse's age? ______{7,8}

What is your spouse's sex? (please circle one) male₉ female₁₀

Please go to question 8.

IF YOU ARE NOT LEGALLY MARRIED, PLEASE ANSWER QUESTION 5:

5. For the purposes of this survey, two people are considered "nonmarital partners" if they are not related to each other, neither is married, they reside together, and they agree to be jointly responsible for their basic living expenses.

Is there someone that you consider your nonmarital partner under the above definition? (please circle one) YES₁ NO₂

If you answered NO, please go to question 8.

IF YOU ARE NOT LEGALLY MARRIED AND YOU DO HAVE A NONMARITAL PARTNER, PLEASE ANSWER QUESTIONS 6-7:

6. What health insurance coverage does your nonmarital partner have currently? (please check all that apply)

- ☐ Coverage under your city employee health insurance
☐ Coverage obtained through your nonmarital partner's employer
☐ Other health insurance coverage (please indicate whether
☐ group or
☐ individual coverage)
☐ No health insurance

What is your nonmarital partner's age? _____₇₋₈

What is your nonmarital partner's sex? (please circle one) male, female₁₀

7. Under the City Charter, the cost of health insurance for family members (including nonmarital partners) must be covered by the premiums charged to employees. The premium for nonmarital partners has not yet been set. The following table contains a range of different possible premiums. For each possible premium, please indicate whether or not you would choose to enroll your nonmarital partner:

Premium per person per month	Would you enroll your nonmarital partner? (circle one)
\$110	YES ₁ NO ₂
\$150	YES ₃ NO ₄
\$200	YES ₅ NO ₆
\$250	YES ₇ NO ₈

8. The Task Force is also examining the possibility of offering health insurance coverage to other extended family members of city employees. Under the city charter, if health insurance were offered to these extended family members, the full cost would have to be covered by the premiums paid by employees. Because extended family members (especially parents) may have higher medical expenses than employees, it might be necessary to charge a premium much higher than the current premium for dependents (about \$110 per month). The premium has not been set.

Categories of Extended Family Members:

- (a) your parents
- (b) your brothers and sisters
- (c) your adult children
- (d) the parents of your spouse or of your nonmarital partner
- (e) the brothers and sisters of your spouse or of your nonmarital partner
- (f) children of your spouse or of your nonmarital partner who are not your dependents (dependents are presently covered).

In the following table, several possible premiums are indicated. For each possible premium, please indicate the number of extended family members you would choose to enroll:

Premium per person per month	Number of extended family members you would enroll (please circle one)				
\$110	0	1	2	3	more than 3
\$150	0	1	2	3	more than 3
\$200	0	1	2	3	more than 3
\$250	0	1	2	3	more than 3

If you answered "0" on each line, please go to question 10.

**IF YOU WOULD ENROLL ONE OR MORE EXTENDED FAMILY MEMBERS
AT A PREMIUM OF \$110 PER MONTH, PLEASE ANSWER QUESTION 9**

9. Please provide the following information for each extended family member you would choose to enroll:

	Category (from list above) (circle one)	Age	Sex (M or F)	Do you share living ex- penses?	Does person live with you?	Can person be claimed as a dependent on your taxes?
Person 1	a b c d e f ₁	____ ₁₂	____ ₁₃	Yes ₁₅ No ₁₆	Yes ₁₇ No ₁₈	Yes ₁₉ No ₂₀
Person 2	a b c d e f ₁₁	____ ₁₂₃	____ ₁₃₄	Yes ₁₅ No ₁₆	Yes ₁₇ No ₁₈	Yes ₁₉ No ₂₀
Person 3	a b c d e f ₂₁	____ ₂₂₃	____ ₂₃₄	Yes ₂₅ No ₂₆	Yes ₂₇ No ₂₈	Yes ₂₉ No ₃₀
Person 4	a b c d e f ₃₁	____ ₃₂₃	____ ₃₃₄	Yes ₃₅ No ₃₆	Yes ₃₇ No ₃₈	Yes ₃₉ No ₄₀

10. Do you have any dependent children? (circle one) YES, NO,
If you answered NO, please go to question 12.

IF YOU HAVE DEPENDENT CHILDREN, PLEASE ANSWER QUESTION 11

11. What health insurance coverage do your dependent children have currently?
(please check all that apply)
- ☐ Coverage under your city employee health insurance
 - ☐ Coverage obtained through your spouse's employer
 - ☐ Other health insurance coverage (please indicate whether
☐ group or
☐ individual coverage)
 - ☐ No health insurance

12. Adult Day Health Care is a program for frail, elderly and disabled adults who might otherwise have to be placed in a nursing home. It allows them to live at home while getting the daily medical, rehabilitative and social services they need during the daytime at a non-profit center.

How many members of your extended family would benefit from adult day health care?
(please circle one)

0 1 2 3 more than 3

Thank you for taking the time to complete this questionnaire.

**Please return it to the Task Force in the enclosed envelope
no later than February 10, 1990.**

The return address is:

**Mayor's Task Force on Family Policy
c/o Mr. Edwin Lee**

**Office of Employee Relations
City and County of San Francisco
1390 Market Street, Mezzanine Floor, Suite 250
San Francisco, CA 94102**

APPENDIX D

ESTIMATES OF COST OF DOMESTIC PARTNER COVERAGE

The Task Force calculated the actuarial value of payments to Bridgeway and Bay Pacific, on the assumption that, for the purposes of the agreement, domestic partner HIV-related costs would be defined as

- the cost paid by the HMO for AZT (or any drug which may become licensed as a substitute for AZT) prescribed for the domestic partners of City employees; and
- the cost paid by the HMO for all medical care of domestic partners of City employees performed on or after the first date in the domestic partner has been diagnosed with AIDS under the Surveillance Case Definition for AIDS of the Centers for Disease Control in effect June 1, 1990.

We assume that all domestic partnerships in which both partners are male are in fact gay male partnerships. We assume that, within the group of domestic partners, only gay males will experience HIV-related costs. According to the survey, 1.9% of City employees are male and would enroll a male domestic partner in the health insurance plan. It is estimated that 50% of gay men in San Francisco are HIV+.¹

An estimate of the potential AZT costs can be made from data obtained through the San Francisco Men's Health Study.² In the first half of 1989, 50 out of 384 (13%) of individuals in the cohort who were HIV+ but did not have AIDS were taking AZT at the time of their semi-annual interview. Assuming that 13% of HIV+ individuals will take AZT at any given time, and that they will take it at the currently recommended dosage of 600 mg./day, at an annual cost of \$3,200,³ the estimated cost would be

$$.019 \times .50 \times .13 \times \$3200 / 12 = \$0.33$$

per active City employee per month. Since there are 31,000 active City employees, the total cost of AZT for the entire group of domestic partners in all plans would be $31,000 \times \$0.33 = \$10,200$ per month, or \$112,800 per year.

An alternative calculation can be made utilizing data on the nationwide volume of sales of AZT. Usage nationwide in the year ending August 1989 was approximately 27,000,000 mg./day; dividing by an estimated 500,000 HIV+ individuals nationwide yields an estimate of 54 mg./day per HIV+ individual.⁴ New guidelines call for greatly extending the use of AZT to individuals who are HIV+ but asymptomatic for AIDS, but reducing the dosage from 1,200 mg./day to 600

mg./day; it is unclear whether the net effect of these two recommendations will be to increase or decrease the total quantity of AZT prescribed. At a cost of \$6400 per year for a dosage of 1,200 mg./day, the cost of AZT per HIV+ individual is estimated to be $\$6400 \times 54 / 1200 = \288 per year. This yields an estimate of

$$.019 \times .50 \times \$288 / 12 = \$0.23$$

per active employee per month for AZT. Since this yields a lower figure than our previous estimate of \$0.33 per active City employee per month, it strengthens our confidence that the \$0.33 figure is sufficiently large.

We have assumed that any new drug such as DDI which is licensed as a substitute for AZT will be taken in place of, rather than in addition to, AZT. In addition, we have assumed that the cost of the new drug at the recommended dosage will not exceed the cost of AZT at its recommended dosage. It is entirely possible that the introduction of a substitute drug would result in a lowering of the price of AZT; if so, our estimates are pessimistic.

It is estimated that 6% of HIV+ individuals will develop AIDS as defined in the Surveillance Case Definition of the Centers for Disease Control in each year.⁵ Thus, the total number of domestic partners in all City health plans who would develop AIDS each year is estimated to be

$$31,000 \times .019 \times .50 \times .06 = 18.$$

The total number of males aged 18 to 64 in San Francisco was 236,391 as of the 1980 census,⁶ while the rate of new AIDS diagnoses per year among this cohort has been very close to 1,600 in each of 1987, 1988, and 1989.⁷ Thus, in a random sample of 2,100 male San Franciscans aged 18 to 64, the expected number of new AIDS cases per year would be

$$1600 \times 2,100 / 236,391 = 14.$$

We estimate the average total health care costs per person following an AIDS diagnosis at \$50,000.⁸ This yields an estimate of

$$.019 \times .50 \times .06 \times \$50,000 / 12 = \$2.38$$

per active employee per month. Thus, the estimated domestic partner HIV-related costs amount to $\$2.38 + 0.33 = \2.71 per active employee per month.

This estimate of the actuarial value of the costs to the Health Service System is probably too high, for three reasons:

1. surveys of this type tend to overestimate the number of people who will purchase a product (in this case, health insurance) because
 - a) people who find the product useful are more likely to respond to a survey than those who do not; and
 - b) some people who indicate they are willing to pay for the product when surveyed choose not to purchase it when they are confronted with the need to actually pay the amount required;

thus, the estimate that 1.9% of City employees are male and would enroll a male domestic partner is probably too high;

2. as indicated above, the estimate of \$50,000 lifetime costs after an AIDS diagnosis is probably too high; and

3. as indicated above, the estimate of a 50% HIV infection rate among gay male domestic partners is probably too high.

Even under extremely pessimistic assumptions about adverse selection, the actuarial value of the domestic partner HIV-related costs remains reasonable. The survey indicated that 2.8% of City workers are male and have a male domestic partner; 1.9% would enroll the domestic partner in City health insurance, while 0.9% would not enroll the domestic partner. Using the estimate that 50% of gay men in San Francisco are HIV+, we conclude that 1.4% of City workers have an HIV+ domestic partner. If we assume that every HIV+ domestic partner is enrolled, then the 1.9% who would be enrolled would be divided into 1.4% HIV+ and 0.5% HIV-. Under this extremely pessimistic assumption, the actuarial value of domestic partner HIV-related costs would be

$$.014 \times .13 \times \$3,200 / 12 = \$0.49$$

$$.014 \times .06 \times \$50,000 / 12 = \$3.50$$

for a total cost of \$3.99 per active employee per month.

Approximately half of patients who begin taking AZT stop taking it because of side effects, which sets an upper bound of 50% of HIV+ individuals who will take AZT. In the medium term, it seems extremely unlikely that more than 25% of HIV+ individuals in San Francisco will take AZT at the 600 mg./day dosage. Given this very high assumption on AZT usage, the total cost of AZT would be

$$.019 \times .50 \times .25 \times \$3200 / 12 = \$0.63$$

per active employee per month, for a total actuarial value of cost of \$3.01 per active employee per month.

If one makes these very pessimistic assumptions on both adverse selection and AZT usage, the actuarial value of costs amounts to

$$\begin{aligned} &.028 \times .50 \times .25 \times \$3200 / 12 = \$0.93 \\ &.028 \times .50 \times .06 \times \$50,000 / 12 = \$3.50 \end{aligned}$$

for a total of \$4.43 per active employee per month.

Under the agreement, Bridgeway and Bay Pacific agree to assume full responsibility for costs between \$3.00 and \$4.00, and 50% of the cost for amounts between \$4.00 and \$8.00. Thus, if one makes the very pessimistic assumptions on either adverse selection or the use of AZT, the actuarial value of the cost to the Health Service System is limited to \$3.00 per active employee per month. Only if one makes both of these very pessimistic assumptions does the actuarial value of the cost to the Health Service System exceed \$3.00, and even then the actuarial value of the cost to the Health Service System is limited to \$3.22 per active employee per month.

1. W. Winkelstein, Jr., et. al., "Sexual Practices and Risk of Infection by the AIDS-Associated Retrovirus: The San Francisco Men's Health Study," Journal of the American Medical Association 257(1987), 321-325; and W. Winkelstein, Jr., et. al., "The San Francisco Men's Health Study, III: Reduction in Human Immunodeficiency Virus Transmission Among Homosexual/Bisexual Men in San Francisco, 1982-86," American Journal of Public Health 77(1987), 685-9; and W. Winkelstein, Jr., et. al., "The San Francisco Men's Health Study: Continued Decline in HIV Seroconversion Rates Among Homosexual/Bisexual Men," American Journal of Public Health, 78(1988), 1472-4. These studies indicate that the rate of infection levelled off at 50% in the mid 1980's. The sample was composed of gay men aged 25 to 55 in 1984 living in the areas of San Francisco hardest hit by the epidemic. There are reasons to believe that the rate of HIV infection among gay male domestic partners of City employees will be lower than 50%. First, the results of the Winkelstein study apply to gay men who are currently aged 31 to 61; the study indicates that most who became infected did so prior to 1985, when an intensive education campaign was begun. It is generally believed that the education program has resulted in a much lower rate of infection among younger gay men; when they are included, the average infection rate among gay men would be lower. Second, men who are currently in stable domestic partnerships may be less likely to be infected than gay men at large. The San Francisco Health Department recently reported that 50% of gay and bisexual men receiving treatment at City sexually transmitted disease clinics are HIV+; it is very likely that the incidence of infection among gay men generally is lower.

2. Telephone conversation May 31, 1990 with Michael Samuel, San Francisco Men's Health Study, School of Public Health, University of California at Berkeley. We are grateful to Mr. Samuel and to Warren Winkelstein, Jr. for permitting us to use these results obtained from the San Francisco Men's Health Study prior to their publication.

3. New York Times, March 3, 1990.

4. Telephone conversation with Joel Hay, Senior Research Fellow, Hoover Institution, May 21, 1990; Hay's figure is derived by dividing total dollar sales of AZT as reported by Burroughs Wellcome by the wholesale price. Hay's estimate of 500,000 HIV+ is below the official estimates of the Centers for Disease Control (CDC). Using the CDC estimate would lower the cost per HIV+ individual, and thus lower our estimated costs of AZT usage.

5. Joel W. Hay, et. al., ("Projecting the Medical Costs of AIDS and ARC in the United States," Journal of Acquired Immune Deficiency Syndromes 1(1988), 466-485), estimates an average 5% progression rate per year in 1988. He currently estimates a 6% progression rate (telephone conversation May 21, 1990). Since the vast majority of HIV infections occurred in the years 1981-1984, the relevant progression rates are for the sixth through ninth years following infection. George F. Lemp, et. al. ("Projections of AIDS Morbidity and Mortality in San Francisco," Journal of the American Medical Association, 263(1990), 1497-1501) report an average progression rate of 5.3% per year in the period 6 to 9 years following infection. The Lemp study employs the best methodology for estimating progression rates, since it is based on AIDS diagnoses and HIV status in a specific cohort. A rough confirmation of the Lemp progression rate figure can be obtained by dividing the rate of AIDS diagnoses in San Francisco, which has remained essentially constant in the range of 1600 per year in 1987 through 1989 (AIDS Monthly Surveillance Report 4/30/90, San Francisco Department of Public Health), by the estimate of 25,000 to 35,000 HIV+ San Francisco residents obtained by W. Winkelstein, Jr. et. al., op. cit; this indicates a progression rate in the range to 4.6% to 6.4%. One study (Peter Bacchetti and Andrew Moss, "Incubation Period of AIDS in San Francisco," Nature 338(1989), 251-253) estimates a higher average progression rate: 7.9% per year in the period 6 to 9 years following infection. However, their estimate is obtained by dividing the number of reported cases of AIDS in San Francisco by an estimate of the number of HIV+ individuals in San Francisco obtained by extrapolating from the Winkelstein et. al. cohort to the population of the City. This methodology is inherently less reliable than the Lemp cohort study because of uncertainty arising from the extrapolation process. If the number of HIV+ individuals in San Francisco were higher than indicated by the Bacchetti and Moss extrapolation (in particular if the number were as estimated by Winkelstein et. al.), the progression rate would be lower. A possible explanation of the discrepancy between the reported progression rates could be that the prevalence of HIV infection is higher among gay men living in the census tracts

studied in the San Francisco Men's Health Study than it is among gay men who live elsewhere in San Francisco. If that were the case, the Bacchetti and Moss progression rate estimates could be valid, but the infection rate among gay men in San Francisco would necessarily be lower than the 50% figure reported by Winkelstein et. al. In this case, the product of the two rates would remain 3%. Since it is the product of the infection rate and progression rate that drives our cost estimates, our estimates would remain valid.

6. 1980 U.S. Census of Population.

7. AIDS Monthly Surveillance Report 4/30/90, San Francisco Department of Public Health.

8. The first published estimate of lifetime medical costs per AIDS patient, \$147,000 (A. M. Hardy, et. al., "The Economic Impact of the First 10,000 Cases of Acquired Immunodeficiency Syndrome in the United States," Journal of the American Medical Association 255(1986), 209-215), has been effectively refuted by the succeeding studies. In 1986, the California Department of Health Services estimated the lifetime medical costs per San Francisco AIDS patient enrolled in Medi-Cal in San Francisco at \$52,000, with an equivalent "commercial" cost of \$74,000 (K. W. Kizer, et. al., "A Quantitative Analysis of AIDS in California," California Department of Health Services, March 1986). Because of the preferential contracts they hold with providers, Bay Pacific and Bridgeway's costs should be close to the Medi-Cal costs. A. A. Scitovsky and D. P. Rice ("Estimates of the Direct and Indirect Costs of Acquired Immunodeficiency Syndrome in the United States, 1985, 1986, and 1991," Public Health Reports 102(1987), 5-17) report costs of \$20,354 per year per AIDS patient in a study of patients receiving all their in-patient, outpatient and professional care at San Francisco General Hospital in 1984. The Scitovsky and Rice study indicates that the expenses are clustered around the period of first diagnosis (\$12,038) and death (\$23,424) and relatively low in between (\$586 per month), suggesting a lifetime cost in the \$40,000-\$50,000 range; the introduction of prophylactic measures may have reduced the high expenditures at the period of first diagnosis since the Scitovsky and Rice study was completed. Joel W. Hay, et. al. ("Projecting the Medical Costs of AIDS and ARC in the United States," Journal of Acquired Immune Deficiency Syndromes 1(1988), 466-485) calculated the total lifetime medical costs using the treatment procedures in place at San Francisco General Hospital in 1988 at \$40,455; he believes this figure accurately reflects the cost of current treatment procedures (telephone conversation, May 21, 1990). R. A. Hiatt et. al. (Archives of Internal Medicine 1(1990), 833-838) found that average lifetime medical costs at Kaiser Permanente facilities in Northern California in the period January 1984 through September 1987 amounted to \$32,816 (1986 dollars). Significantly, Hiatt et. al. found that treatment costs declined substantially over the period of study due to the substitution of outpatient treatment for hospitalization. Both Bay Pacific and Bridgeway agreed to the figure of \$50,000 as a reasonable estimate of their lifetime health care costs per AIDS patient.

APPENDIX E

QUALIFICATIONS OF TASK FORCE MEMBERS
RESPONSIBLE FOR COST ESTIMATES



DEPARTMENT OF ECONOMICS

BERKELEY, CALIFORNIA 94720

June 9, 1990

The Honorable Art Agnos
Mayor, City and County of San Francisco

Dear Mayor Agnos:

As a member of your Task Force on Family Policy, I oversaw the survey assessing City employee health needs and I estimated the costs to the Health Service System of providing domestic partner coverage presented in the Task Force's report. The survey was written by a subcommittee of the Task Force, reviewed by several members of the Economics Department at UC Berkeley and by Mr. David Binder of the San Francisco Poll, tested on a sample of 100 City workers and then mailed to the full sample of 4,568. A total of 1,620 sample forms were returned. Mr. Binder keypunched the response forms and did the preliminary data analysis; I carried out the cross-tabulations, and computed the confidence intervals presented in the report.

I developed the cost estimates for domestic partner coverage presented in the report. The estimates depend principally on factors such as the number of gay male domestic partners who would be insured, the proportion of gay men who have been infected with HIV, the rate at which HIV-infected men develop AIDS, and the medical costs of treating each AIDS case. I am a co-author of two papers on economic issues associated with the HIV epidemic, and have served as a member of the University of California University-Wide Task Force on AIDS, the scientific review panel for grant proposals from University of California AIDS research funds. The estimates were based on a review of the scientific literature on the epidemiology of AIDS and the cost of AIDS treatment, supplemented by telephone conversations with leading experts on these subjects, as described in the report.

The figures presented in the report represent my best professional estimate of the costs that will be incurred by the Health Service System if it extends health insurance coverage to domestic partners of City workers.

Sincerely,

A handwritten signature in dark ink, appearing to read "Robert M. Anderson". The signature is fluid and cursive, with a large initial "R" and "A".

Robert M. Anderson
Professor and Department Chair

NOBLE
LOWNDES

Consultants
& Actuaries

June 11, 1990

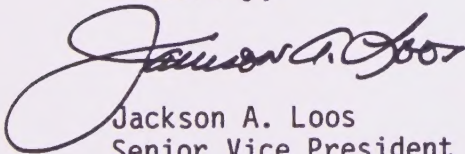
The Honorable Art Agnos
Mayor, City and County
of San Francisco
Room 200, City Hall
San Francisco, California 94102

Dear Mayor Agnos:

Since the mid-1970's I have provided consulting services to primarily large multi-employer health and welfare plans. As consultant, I am responsible for the analysis of benefit costs, including reviewing current and projecting future medical plan expense, calculating the effect of plan modifications, and designing cost management techniques to control medical cost increases. As a member of your Task Force on Family Policy, I worked with the sub-committee which was directed to assess the costs to provide health coverage for domestic partners and extended family. Along with other members of the Task Force, I met with Kaiser, Bridgeway, and Bay Pacific to determine how such coverage would best be provided and at what cost to the City's Health Plan.

Having been in the industry for over 15 years, I have written a number of articles and spoken before numerous groups regarding health cost. I have been recognized as an expert witness in the area of health benefits. Based on my professional expertise, I feel that the report prepared by the Task Force represents the best professional estimate of the costs which would be incurred by the Health Service System to provide health coverage to the domestic partners of City Workers.

Sincerely,



Jackson A. Loos
Senior Vice President

JAL:ct

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